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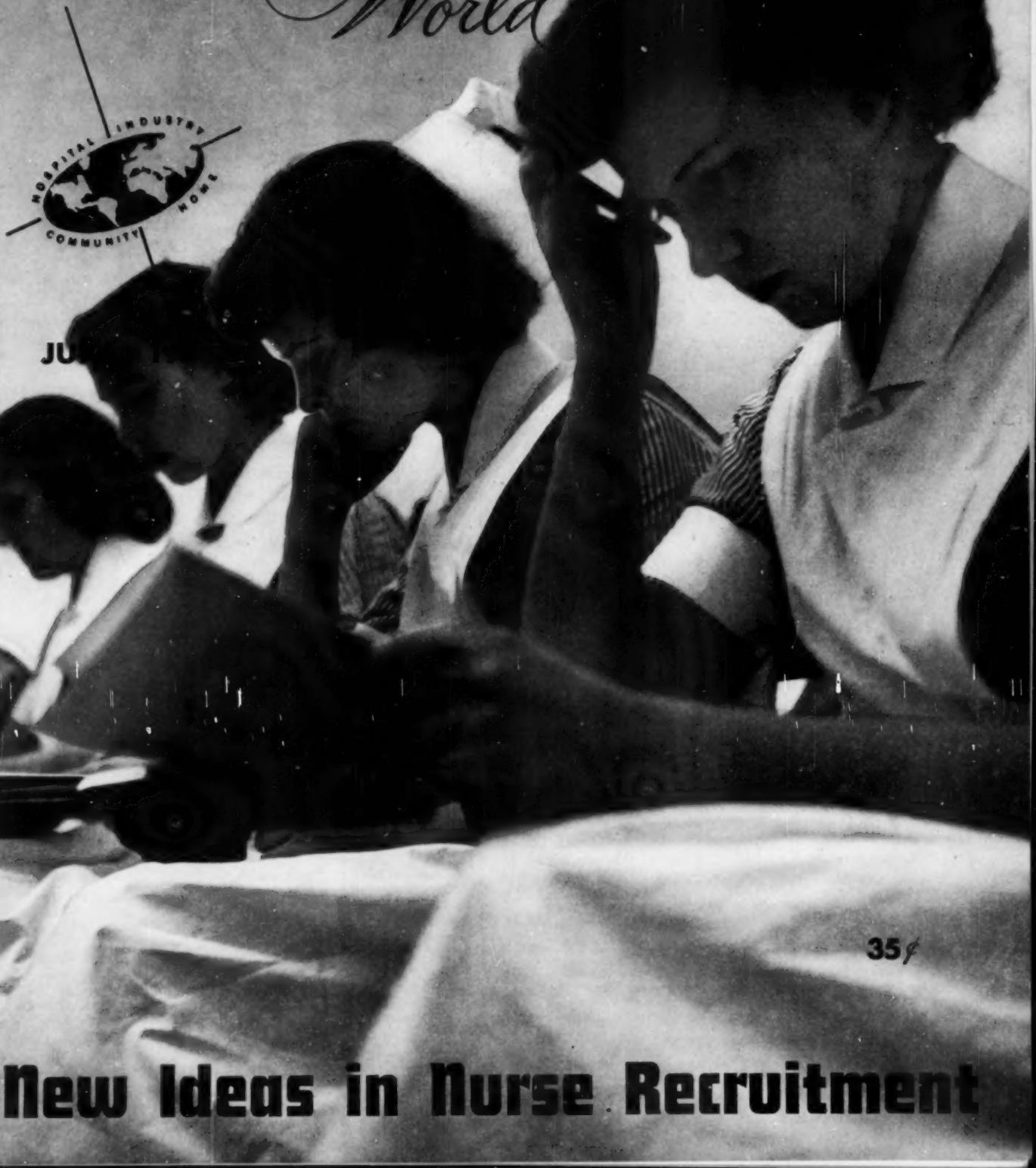

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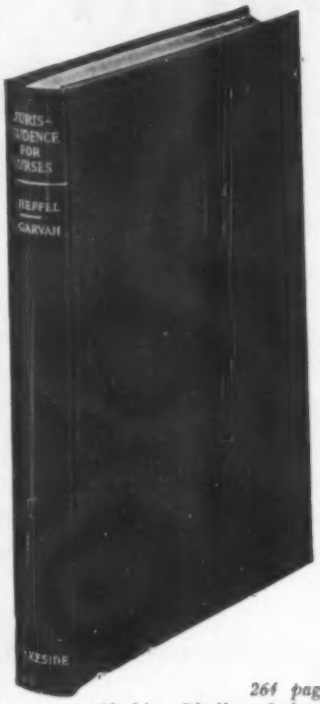

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In This Issue

COVER: On the threshold of a noble career. These young ladies have already decided to cast their lot with the thousands of women who have studied and worked for the good of humanity. (*Photo, Stan Lee, courtesy of Committee on Careers, National League for Nursing, New York City.*)

Mary Ernsting, R.N.

Harry Ernsting, M.D.

Mary and Harry Ernsting, who wrote the article about corneal transplantation on page 34, are collaborators in more than the literary field. Dr. Ernsting is a practicing ophthalmologist, a Diplomate of the American Board of Ophthalmology, a Fellow of the American Academy of Ophthalmology and Otolaryngology, and a Fellow of the International College of Surgeons. Mrs. Ernsting, R.N., is a graduate of the Christ Hospital School of Nursing and has been a general duty nurse, an office nurse, a nursing arts instructor, and an assistant director of nurses. She has held offices in the Ohio State Nurses Association (District 11) and is at present engaged in nurse recruitment.

Anne Middlemiss, R.N.

Anne Middlemiss is vitally interested in one of the most pressing problems of the day—how to interest young women in a nursing career. Her story on page 21 relates one method that has been found successful. Miss Middlemiss, who was born in Hibbing, Minnesota, spent three years of her childhood in South America where her father was a mining engineer. She has a Bachelor of Nursing degree from the Yale University School of Nursing and has held many important posts in the United States as well as in South America. At present she is Director of Nursing Education at the Middletown Hospital, Middletown, Ohio.

Sister Mary Jean, R.N.

One of the grave medical and surgical problems that require special nursing skills is outlined by Sister Mary Jean, C.D.P., on page 15. The author obtained a Bachelor of Science degree in Nursing Education from the Catholic University of America, Washington, D. C. After supervisory work and teaching at St. John's General Hospital, she was transferred in 1951 to Mercy Hospital, Pittsburgh, Pa., where she is now a clinical instructor.

How to make ends meet is a concern of all nurses—a group famous for financial inanition. Marion Stevens Eberly, Women's Division Director, Institute of Life Insurance, who has made figures her business, relays some helpful budgetary hints (page 10).

Nursing World Reports:

International—NURSES ABROAD: In Thule, Greenland, formerly a "man's world," the U. S. Northeast Air Command recently assigned three nurses to its newly-opened 50-bed hospital, making Capt. S. M. Schat, Highland Park, Michigan, Lt. C. A. Stevens, Arlington, Virginia, and Lt. H. M. Costa, Roslindale, Massachusetts, the first women in the nation's history to be permanently stationed by the Armed Forces so near the top of the world.

The home-nursing division of the American Red Cross has sent to its Far Eastern theatre Mrs. Wendell A. Weller, a Major in the Army Nurse Corps Reserve, to act as a volunteer consultant in the recruitment and training program of nurse-teachers.

The U. S. Foreign Operations Administration (FAO) recently assigned Ann M. Thomson, Milton, Massachusetts, as a public health nursing consultant to its mission in Karachi, Pakistan. It also stationed Evelyn Zimmerman, Spring Valley, New York, as a nursing consultant in its theatre in Panama, and sent Alice M. Fay, New York City, to Formosa as a senior nurse.

National: The ANA is supporting the recommendation of its Committee on Nursing in National Defense that nurses contribute to the country's long-range defense program by serving at least two years in military service.

Congresswoman Frances P. Bolton (R., Ohio) recently introduced a resolution into the U. S. House of Representatives that the first full week in October 1954 be proclaimed National Nurse Week "to interpret nursing more fully and more interestingly than it has ever been brought to the public before. . ."

Nurses are volunteering their services in the polio vaccine program of the National Foundation for Infantile Paralysis in trial areas in the United States. Three injections of 1 cc each will be given before the start of the polio season to children in the first, second and third grades. Only about half of them will get the vaccine; the other half will receive a similar-appearing but ineffective fluid for control studies.

Discussing the important subject of counseling of nurses at the recent meeting of the Southern New York League for Nursing Institute, held in Manhattan, I. Marguerite Perry, Chief of Nursing Service, Veteran's Administration Hospital, Brooklyn, said: "We talk about the recruitment of nurses—have we ever thought about the salvaging of nurses, keeping those we have happy and willing to remain nurses? This is something good counseling can do."

Coming Conferences, Institutes and Study Programs: A Conference on Legislation is scheduled for June 28-30, 1954 at Moraine-on-the-lake, Highland Park, Illinois (just outside Chicago), which will include proposals for reorganizing the administration of nurse-licensing laws and ways to influence state and federal legislation.

A Nurses Institute on Alcoholism will be held from July 29-31, 1954 at Yale University. From July 6-16, 1954 a short course on the Nurse and the Law is being offered by the Extension Division of the University of California. Three hundred leaders in the political, governmental and civic fields, including Ovetta Culp Hobby, Adlai Stevenson and Mrs. Eleanor Roosevelt, will take part in a conference on National Policies for Education, Health and Social Services from June 2-5, 1954 at Columbia University.

A 52-week course in anesthesiology and a 22-week course in operating room technique and management are being given, beginning August 30, 1954, at selected Army hospitals for Army Nurse Corps officers, both Regular and Reserve. (Inquire: Department of the Army, Office of Surgeon General, Technical Liaison Division, Washington 25, D. C.)

An examination for nurse anesthetist ($4,620 and $5,810 a year) was recently announced (no closing date) by the U. S. Civil Service Commission.

People: Celia Cranz, former Director of Akron City Hospital School of Nursing, was recently elected General Secretary of the Ohio State Nurses' Association.

Estelle H. Osborne, winner of the Mary Mahoney Medal of the former National Association of Colored Graduate Nurses and a previous Assistant Professor at New York University, was appointed Assistant Director for General Administration at the National League for Nursing.

Eleanor M. Schetlin, Director of Recreation and Guidance, Metropolitan Hospital School of Nursing, New York City, recently made a survey of student guidance in twenty-seven schools of professional nursing in this country and reports that "in most of these schools the educational director does most of the student counseling."

Occupational Health Nursing: In the words of Mrs. Gay Merrihue at the American Association of Industrial Nurses, this organization "has developed recently 'A Statement of Principles to Govern Management Relationships with the Industrial Nurse' which is designed to raise the status of the nurse in industry, and which is being very well received and frequently requested by company management." It deals with such problems as factors determining the nurse's salary and her working relationship with supervisors and other management people.

Industrial Health: Tetrachlorethylene is the recent anthelmintic advocated for hookworm disease to replace the more toxic drug carbon tetrachloride, according to Drs. A. Goldbloom and L. J. Boyd. However, tetrachlorethylene produced toxic manifestations in a patient suffering from infectious (virus) hepatitis and nonsymptomatic hookworm infestation. The physicians recommend that hepatic function tests should be performed before any of the hydrocarbons are administered to exclude latent hepatic disturbance. Tetrachlorethylene should not be given in such conditions as alcoholism, hepatic disease and toxic conditions. Since it is used as a dry cleaning agent in the printing industry and as a constituent in solvent soaps, one should remember that tetrachlorethylene is a drug not without danger.

There are two to four million alcoholics in this country. It is important to know how to recognize the earlier phases of this disease if more are to be saved from it. Professional

people attending the recent Industrial Hygiene Foundation Meeting in Pittsburgh were told to look for swings of mood from showy exaggeration and bragging to low periods when the victim avoids all personal relationships. These manifestations are usually accompanied by consistent tardiness or absence on Monday mornings and early departure from work on Friday afternoons; recurring excuses for minor illnesses; irritability in an otherwise placid worker—criticism of others, arguments, disinterest in work, slowness, self-defense for recurring mistakes; and minor accidents for which he blames others or equipment.

"You Don't Know How to Listen" says Dr. Ralph Nichols in the July 25th issue of *Colliers Magazine*. Industrial nurses who pride themselves on being good listeners might check themselves against this list which Dr. Nichols says are the most common listening faults: (1) Hop-skip-and-jump listening, (2) "I-Get-the-Facts" listening, (3) Emotional deaf-spots, (4) Supersensitive listening, (5) Avoiding difficult explanations, (6) Premature dismissal of a subject as uninteresting, (8) Pretending attention, (9) Yielding to distractions, (10) Pencil-and-paper listening.

Chemical Week, a trade publication (McGraw-Hill), recently decided to find out what the well-dressed woman in industry was wearing. It found that most chemical companies provided uniforms for their women employees, and that the purely functional uniform—protection against acids, alkalies, and machinery, but no style—is meeting employee resistance. One curvaceous worker complained that the uniform would look just the same if she wore it upside down. In many places the girls are demanding and getting uniforms that are "trim, stylish, chic, eternally feminine, altogether fetching, and more shapely."

For the last decade management recruiting has been putting a strong account on youth. Things had gone so far that "old men" in their forties were finding it hard to change jobs. Recently *Factory Management and Maintenance* saw an ad in the *New York Times* asking for a man "between the ages of 50 and 65." The advertiser explained that the company wanted an older person because "their business required a mature man to deal with refined people."

The Aluminum Company of America has on the market a lightweight aluminum litter-cot for easier handling of casualties. It weighs only 27 pounds but is strong enough to be stacked four-high like bunk beds. The legs can be folded under when it is being used as a litter, and extended when it becomes a cot.

Nurses' Symbol: Wanted by 1956 by the ANA a 1956 Symbol for American Nurses or Nursing in the form of an idea or a design, to be submitted with supporting research before December 31, 1955 to Public Relations Unit, ANA, 2 Park Avenue, New York City 16, New York.

Scholarships: A $275 tax-free monthly cash allowance as well as payment of tuition costs is being offered in 1954 to male or female registered nurses not over forty years old who wish to train for Kenny therapist positions. Classes start August 1, 1954 and graduation is in December 1956. (Apply to Director of Training, Sister Elizabeth Kenny Foundation, 1800 Chicago Avenue, Minneapolis, Minnesota).

The Pennsylvania Tuberculosis and Health Society offers a Pennsylvanian nurse a one-year scholarship of $2,000 for advanced study, in an accredited graduate school, of administrative or other professional service in tuberculosis or public health work.

Practical Nursing: Recently appointed as members of the new Practical Nurse Advisory Committee by the New York State Board of Regents were Mrs. Lillian K. Sterling, Albany; Mrs. Catherine B. Quell, Richmond Hill, Queens; and Kathleen Manion, Rochester.

The National Association for Practical Nurse Education will sponsor separate workshops (with college credit) for practical nurses and professional nurse instructors and directors at the University of Maine, from June 6-23, 1954, and at the Colorado Agricultural and Mechanical College, from July 26-August 13, 1954. For practical nurses, there will be an advanced course and a regular course in organizational leadership and community relations. (To secure added information, write: Hilda M. Torrop, Executive Director, National Association for Practical Nurse Education, 654 Madison Avenue, New York 21, New York.)

The Kentucky State Association of Practical Nurses, District 1, has a new project delivering Sunshine Baskets to ill members or to those confined at home.

Convention: Since its establishment in 1941 the National Association for Practical Nurse Education has been engaged in raising the standards of schools of practical nursing, accrediting those schools meeting its requirements, aiding in the recruitment of practical nurse students, and serving as a clearing house for information in this field.

At its convention held in San Antonio, Texas, April 26 to May 1, 1954, Mr. Joseph LeRoy was elected First Vice-President and Mr. Alan H. Kempner, Treasurer. Mr. LeRoy is Vice-President of the Guaranty Trust Company, New York City. Mr. Kempner is a member of the Board of Trustees, Hospital for Joint Diseases, New York City.

The following were elected to the NAPNE Board of Directors:

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Mrs. Mary S. Wiles, R.N., Director, School of Practical Nursing, Harlem Y.W.C.A., New York City.

Clara Weigel, Executive Secretary, Practical Nurse Association of Colorado.

At the Annual Convention of the American Nurses Association, Myrtle H. Coe, Assistant Professor at the University of Minnesota School of Nursing, had something to say about the nurse's role in the rehabilitation of the chronically ill. She pointed out that "cardiac patients are the largest group in need of rehabilitation services" and recommended that nurses aid these people to "identify themselves with well folks" by helping to get them out of bed for meals.

New Publications: *Transactions of the Industrial Hygiene Foundation;* A series of talks was given at the 18th Annual Meeting on such subjects as industrial noise, alcoholism, human relations, and absenteeism.

Occupational Disease Reporting: *A Review of Current Practices Together with a Collection of Incidence Statistics* by Victoria M. Trasko, Washington, U. S. Department of Health, Education, and Welfare, Public Health Service, 1953, 80 pp., bibliography. (PHS Pub. 288) 40 cents, Superintendent of Documents, Washington, D. C.

WHAT 142,045* THINK

by Mary Mesecher, R.N., Executive Secretary, Third District, Minnesota Nurses Association

IF you attended the General Duty Section meetings at the American Nurses Association Convention in Chicago the last week of April you know that the assembled nurses at the very beginning adopted a preamble which said: "The guiding principle in defining the functions of general duty and head nurses shall be to establish the broad level at which the professional skills of these nurses may be utilized to the fullest extent in providing optimum nursing to the consumer. This shall include determining the need for and review of existing programs aimed at increasing the abilities and skills of general duty and head nurses."

They also agreed that "The general duty nurse is aware of the total nursing needs of the patient and is responsible for seeing that they are fulfilled." The first step in meeting the patient's nursing needs is to "prepare, administer and supervise a patient-care plan for each patient for whom the general duty nurse is responsible."

Sound familiar? Yes! General duty nurses endorsed the team approach as a technique for giving improved nursing care. But while hundreds agreed on the basic premise it did not mean they were ready to accept just any version of the team plan for bedside care.

The general duty nurse is put in the position of team leader without leadership training, they protested, and without a clear understanding of her relationship to other nursing personnel, including the head nurse. The Health Resources Advisory Committee of the Office of Defense Mobilization in the pamphlet *Meeting Your Hospital Personnel Shortage* says:

> Constant attention should be given to the development of leadership skills since only 10 per cent of management is specific "know-how." Ninety per cent is ability to work with others. Hospital trustees, administrators, physicians, dentists and directors of nursing should recognize the importance of training in leadership skills for all supervisory nurses and most staff nurses. Potential leaders must be developed from present hospital staffs. Hospitals should provide such training on an in-service basis and leaders should be selected on the strength of demonstrated ability regardless of academic training or length of service.

In line with their realistic approach toward making our present nurse power go farther, the general duty nurses at the convention were well aware that not every general duty nurse has the personality to be a team leader. But on one point they were most adamant—there will always be a place on the team for the skillful professional nurse.

Other points discussed in administering the team plan were need for:

- An evaluation of the patient's spiritual, emotional, social and economic needs, habits and resources.
- An awareness and skilled use of available resources, personnel and physical facilities of the hospital and community.
- Cooperative efforts and shared responsibility with head nurse, supervisor and attending physician.
- Establishing contacts with the family and other visitors necessary in preparing the plan and its effective execution.
- An interpretation to the patient that he himself is the most effective resource in promoting successful therapy and rehabilitation.
- A knowledge of purpose, principles and precautions associated with drugs, therapeutic methods and diagnostic tests in the nurse's clinical area.

Assisting in patient education and rehabilitation, observing patients for symptoms and reactions, the constant evaluation of nursing procedures in the light of nursing and medical progress, and the judgment of the nurse in adapting nursing procedures to individual patient-needs were considered basic to meeting the nursing needs of the patient.

There were several examples of the very rigid nurse who does not use judgment in adapting nursing procedure to individual patient-needs. The stories drew laughs but, as many of us realized, they were all too true. There was the story about a night nurse who followed the old-fashioned and patient-deplored routine of waking her charges every morning at five. The convalescence of one patient, a severe cardiac who had just fallen asleep when he was disturbed by the early morning clatter, was prolonged for several weeks. Yes, the nurse knew he had just dropped off to sleep, but the routine morning work must be done. At the expense of a patient's recovery? There can be danger when a nurse becomes work-centered rather than patient-centered.

An important phase of team planning discussed at the convention was teaching non-professional personnel to observe and report symptoms, reactions and progress to the appropriate person. General duty nurses realize that in effectively directing the skills and efforts of non-professional personnel, better nursing care will be the rule and all nursing personnel can derive increased job satisfaction.

The role of the general duty nurse in administration of nursing service and in the community was the subject of considerable discussion. Because the proposed functions for general duty nurses contain startling and dramatic principles for administration of nursing service the next article will be devoted in its entirety to an exploration of the participation of the general duty nurse in nursing service administration.

The nursing service reflects the philosophy of the administrative personnel. The goals of nursing service can be achieved only through the coordinated effort and will of all personnel. Effective organization of nursing service encourages a full flow of ideas upward, downward and across all departmental plans and problems. Morale and the factors which influence its development are of paramount importance in the quality of nursing service; therefore, recognizing and overcoming barriers of communication which will result in the participation of all nursing personnel are the first steps in meeting today's nursing demands.

Can You Live on Your Pay?

An authority on figures considers the frequently threatened financial health of nurses and plans for a favorable prognosis.

by Marion Stevens Eberly,
Director,
Women's Division, Institute of Life Insurance

YOU are a professional nurse, and you work hard for your money. If you are a salaried nurse, your payroll deductions seem to play havoc with your check. If you do private duty, your financial life is complicated because you may not receive the same sum week after week, and every March 15 there is the problem of Federal Income Tax.

However you get your income you often wonder how you will make ends meet with a check *that* size. Somehow —you manage to stretch your money until the next pay day finally creeps up. But you have to pinch pennies, and you hate the feeling that comes of pinching pennies.

You ask yourself, "Is there any way a girl can manage her income to better advantage?"

The answer is, "Yes, by means of a budget.

Now don't let the word "budget" discourage you. Perhaps you've had exasperating experiences with budgets that called for detailed bookkeeping and a "watch-over-every-nickel" attitude. In spite of them, I can show you a simple, down to earth plan, that in four steps will let you analyze your expenses, balance them against income and, sooner or later, help you keep your head above water, financially speaking.

Nurses especially must keep their money in good order. Despite professional status, the take-home pay of many a nurse falls into the lower middle income bracket. Moreover, a substantial number of nurses (like most women who work) have assumed financial obligations beyond just supporting themselves. For example, it is not unusual for a nurse to contribute to the support of a parent, or to help in the cost of educating a younger brother or sister. And many married nurses, of course, work in order to swell the family income.

Good money management, basically, will enable you to make your own dollars go further, but there is this additional advantage: a workable budget can add materially to your peace of mind

because it means you will be less preoccupied with money problems.

The advantage of this particular budget is that it aims to establish spending habits that you find fit *your* income and expenses. At first you will have to to some figuring, but the simple arithmetic will pay off by letting you know how much to set aside every pay day for "must" expenses. Once you get the habit of the set-aside you can put away the formal budget and rely on habit alone to manage your money.

Although you may not be aware of it, you already have some kind of financial system. It may work like this. You want to come out even at the end of a week or month. So you postpone buying a dress that has caught your eye. Or you decide to forego the purchase of that expensive Toscanini recording of Beethoven's Fifth Symphony.

Sometimes it is possible to manage on a rule-of-thumb plan, but such a system is inherently dangerous because it allows you little or no control over day-to-day expenditures. That is why it has proved better to follow a logical system.

In essence, this is our budget: if you were to write down all of your "fixed" expenses, the ones you are committed to meet periodically, you learn exactly how much money remains for day-to-day expenses and for saving. This will lead to financial control and perhaps, for the first time, allow you to see where your dollars are going, and why.

Nurses' living arrangements differ so widely that you will have to adapt this budget plan to meet your own situation. If you live in the hospital you won't include rent and utilities in your plan. Or you may share a room on the outside; put down only what you pay towards living expenses, unless you and your roommate pool incomes. If you are married you should have a family budget and include your husband's income, as well as his and the children's expenses, with your own.

As an example of how this might be done, I have given a typical budget for

Miss Kathleen Moskowitz, a registered nurse at the George Washington University Hospital in Washington, D. C., has graciously consented to reenact parts of her active day in specially posed photographs.

Kathleen Moskowitz breakfasts in the apartment she shares with a roommate.

Milk is a costly item in this household of two—12 to 14 quarts a week.

Picking up a fresh uniform. A five-dollar ticket is punched each time a uniform is washed in the hospital laundry (3 to 5 uniforms per week, 40 cents each.)

That last check-up on a patient's blood specimen before turning it over to the laboratory technicians. Fortunately, the uniform is still without a blemish.

Florence N. Green, R.N., an imaginary nurse who lives with her mother. You can easily alter her financial plan for yourself.

STEP I. List your income. Put down how much you expect to earn in the next 12 months, but do not include taxes that will be withheld or other deductions. If your main income is from regular wages, this part is easy.

If you live with your mother and pool both your incomes, add them together. Your mother may be receiving Social Security benefits; perhaps she is the beneficiary of a lifetime annuity that she derives from her late husband's life insurance. Many women have regular income from stock dividends or property.

STEP II. Write down all of the fixed expenses you can think of. A checking account simplifies this step greatly. Examples of fixed obligations are rent or mortgage payments; the cost of fuel, electricity, gas and telephone service; insurance premiums; charitable contributions; installment payments; professional expenses, such as new uniforms or membership fees; clothing expenses and upkeep; and so on. Don't list any figure you cannot estimate very closely. Add them up and divide by 52 to arrive at the average weekly expense.

Your answer will be the weekly set-aside. Every week put this set-aside in the bank or in a special fund. When fixed expenses come due, pay them out of the fund. It may take a while for the fund to grow, but if you stick to it, in due course there will always be enough to meet fixed obligations as they arise.

(If you are paid twice a month, divide your total by 24 to arrive at the sum to be set aside every payday. A special duty nurse has a different problem because her income fluctuates. Perhaps the best approach is for her to calculate her set-aside on a monthly basis, including money toward income tax.)

Florence Green, R.N., an imaginary assistant head nurse in a voluntary hospital in a small town in the central United States, lives in an apartment with her mother, a widow. They pool both incomes to meet expenses. Florence earns $265.00 a month, from which Social Security ($5.30), withholding tax ($28.20) and hospitalization ($3.20) are deducted. Mrs. Green has a lifetime annuity from the $10,000 life insurance left by her husband. Florence launders her uniforms at home. For her mother's protection Florence has $2000 of life insurance on which her premium is $56.00 a year.)

FINANCIAL PLAN—STEP I—INCOME

		Your own Figures
Florence's annual take-home pay ($114.10 twice a month after deductions for Social Security, income tax, hospitalization)	$2738.40	.....
Her mother's income from a lifetime annuity	569.50	.....
ANNUAL TOTAL INCOME	3307.90	.....
WEEKLY TOTAL INCOME	63.61	.....

FINANCIAL PLAN—STEP II—FIXED CBLIGATIONS

		Your own Figures
Rent ($50.00 a month)	$600.00	.....
Electricity and telephone	90.00	.....
Contributions	33.00	.....
Florence's life insurance	56.00	.....
Clothing expenses (including upkeep)	280.00	.....
Professional nursing expenses (includes new uniform)	12.00	.....
ANNUAL TOTAL	1071.00	.....
WEEKLY TOTAL	20.60	.....

It is difficult to pass up the morning "coffee break." The cafeteria is open also for mid-afternoon refreshment as well as for the regular meals of the day.

STEP III. The emergency fund. Its object is to tide you over for several weeks or even months should an emergency arise. These include family emergencies, large medical expenses, household repairs and the like.

How large should your emergency fund be? You'll have to answer that one for yourself, because it depends on your individual circumstances. Some people suggest a reserve equal to one month's income; others feel that a three-month reserve is ideal, although that may be beyond your reach. Whatever your decision, add the amount to your weekly set-aside. When your emergency fund gets big enough, stop putting money into it. But continue to set aside the same amount and add to your savings, increase your life insurance, or put it to some other use.

FINANCIAL PLAN—STEP III—EMERGENCY FUND

Florence and her mother have about $500.00 in their emergency fund (U.S. bonds plus savings account) to cover family emergencies and other unexpected items, and to help make their budget work. This year they'll try to add $2.00 a week.

		Your own Figures
THIS YEAR'S ADDITION TO EMERGENCY FUND	$100.00	.....
WEEKLY SET ASIDE FOR EMERGENCY FUND	2.00	.....

FINANCIAL PLAN—STEP IV—DAY TO DAY EXPENSES

		Your own Figures
THEIR WEEKLY INCOME IS	$63.61	.....
THEIR TOTAL WEEKLY SET ASIDE IS	22.60	.....
THEIR TOTAL WEEKLY BUDGET FOR DAY TO DAY EXPENSES AND FOR SAVINGS IS	41.01	.....
They'll spend this 41.01 as follows:		
Food	22.00	.....
Household expenses and incidentals	4.50	.....
Florence's bus fare to work (50 weeks)	2.40	.....
Florence's personal allowance	4.00	.....
Her mother's personal allowance	2.00	.....
Miscellaneous (ordinary medical expenses, cosmetics, etc.)	4.50	.....
TOTAL	39.40	.....

This leaves them $1.61 a week ($63.61 less $62.00) for regular savings, for vacation and for everything else they have to buy.

The end of the work day. On some days it comes at 4 P.M. but the hospital works three shifts during a 24-hour period and the nursing staff has to alternate.

Whatever one's salary may be, there are times when a gift must be chosen.

STEP IV. Your living expenses.

Take your weekly (or semi-monthly) income and subtract the set-asides. This will give you the sum with which to pay your day-to-day expenses. Among them are food, lesser items of clothing, upkeep of your home or apartment, transportation, personal allowances, recreation and so forth. You'll have to estimate these items as closely as you can and check the total with the amount you have put down for them. If they do not match, refigure the provisions you have made for other things.

To make this portion of the budget as practical as possible, you might assign each expenditure to a given member of the family, unless you live alone. Mother, for example, may have "X" number of dollars for food and household expenses; you will be assigned "Y" dollars as personal allowance and carfare and possibly the "miscellaneous" fund.

Whatever plan you adopt, the amount that remains after expenses can go into regular savings. Don't feel too guilty if once in a while you splurge instead.

A word about credit. This particular budget assumes that you are now financially solvent, but it is flexible enough to absorb the repayment of loans. Now let's say that you want to put this money management plan into effect, but must first clean up outstanding loans or charge accounts.

You may take one of three approaches. If you have a savings account you can "borrow" from it, gradually repaying yourself from your new budget. Or you can actually borrow the money from a bank or other lender, although this may mean you must deal with a financial

Managing a cheerful expression as she pays her share of the expenses for a small apartment (living room, bedroom, kitchen and bath) rented from the University.

"crisis" until the loan is paid off. The third alternative is to run your budget at a deficit, not building an emergency fund until you are in the clear.

You can understand that your first budget may not be tailored exactly to your needs; perhaps "miscellaneous" is too large, or you may have forgotten a major future expense. It will take only a few minutes to refigure, because you have already calculated the major part of your budget. You may decide to carry the plan to its logical conclusion by jotting down exactly what you spend for a couple of weeks. This will give you a true picture of where your money is now going.

Finally, as I have mentioned, comes the best part. When you have gotten into the habit of setting aside enough money every pay day to cover your expenses, file the written budget until a major change in your economic life takes place.

Relaxation from a heavy work schedule and another dent in the budget.

Nylon stockings are as necessary as food and almost as quickly "consumed" —at least one pair of white hose and three pair for dress wear every month.

A date?—an out-of-town girl friend coming to stay for a while? Either possibility is pleasant to contemplate but one will surely affect the budget.

brain tumor . . . before and after surgery

by Sister Mary Jean, C.D.P.,
Clinical Instructor,
Mercy Hospital, Pittsburgh, Pennsylvania

UNTREATED brain tumors, whether benign or malignant, are inevitably fatal. The limited space within the cranial vault makes it impossible for a tumor to grow without causing pressure on or destruction of brain tissue. Surgical removal of intracranial tumors, when possible, is the treatment of choice.

Brain surgery is a highly specialized field which demands great skill on the part of the surgeon. Assuming the competence of the surgeon, however, the success of brain operations depends largely on the nursing care which the patient receives before and after surgery.

There is no typical syndrome to indicate brain tumor. The patient may walk in, stating that he has persistent headaches; he may be brought to the department in a wheel chair, suffering from hemiplegia; or he may come by ambulance, unconscious. The symptoms vary greatly and depend on the size and location of the tumor.

Intelligent and purposeful observation is essential for establishing a definite diagnosis. Some of the more common symptoms of brain tumor which may be reported by the patient or which are observable without special testing are headache, vomiting, paresis or paralysis of any part of the body, visual disturbances, speech disturbances, convulsions, changes in pulse rate and blood pressure, personality changes, stupor. These and any other symptoms should be recorded in detail, stating the nature and degree of the disability, the part of the body involved, etc., as the case may be. Such a record is invaluable to the neurosurgeon in helping him to determine the location of the suspected tumor. Many symptoms are traceable to interference with the function of definite brain areas.

Symptoms which reveal an increase in intracranial pressure (e.g., rise in blood pressure, decrease in pulse and respiratory rates, and progressive loss of consciousness) should be reported to the neurosurgeon at once. He may find it necessary to perform a ventricular tap or even a craniotomy immediately if the pressure has become so great that it threatens to force the medulla oblongata down through the foramen magnum.

Such an accident would result in death or permanent brain damage.

Besides careful observation of symptoms, there are several diagnostic procedures which are of value in establishing a diagnosis of brain tumor and determining the location of the tumor. Most important among these are neurological examination, spinal tap, pneumoencephalogram, and ventriculogram. The patient should be prepared psychologically before each of these procedures in order to allay his fear and secure his cooperation.

No special preparation is necessary for neurological examination except to explain to the patient what is to be done. The doctor observes the patient's appearance, gait, coordination, ability to perform skilled acts, etc. He tests the deep and superficial reflexes, muscle strength, and sensitivity to heat, cold, and pain.

Spinal tap is done to determine the pressure within the spinal canal and to secure a specimen of spinal fluid for laboratory examination. For this procedure, the nurse places the patient on one side with his back close to the edge of the bed, his knees drawn up, and the head brought down to the knees in order to separate the spinous processes of the vertebrae for passage of the needle. Aseptic technique is used. The nurse assists the doctor by supplying all that is needed to perform the tap and by handling anything that is unsterile (e.g., the outside of novocaine vials). The patient should remain flat in bed for several hours after the spinal tap.

A pneumoencephalogram is performed by withdrawing fluid from the spinal canal and injecting an equal amount of filtered air or oxygen; x-rays of the skull are made immediately. The air or oxygen, which is opaque to x-ray, outlines the ventricles of the brain and shows any defect in them which may indicate the presence of a tumor. Food and fluids are withheld for several hours prior to this procedure, and preanesthetic medications may be ordered. Signed permission must be obtained from the patient or his nearest relative.

Pneumoencephalogram is contraindicated if there is any block in the circulation of the cerebrospinal fluid. The ventricles may then be outlined by ventriculogram. This is a surgical procedure whereby fluid is withdrawn through perforations in the skull; air or oxygen is injcted directly into the ventricles, and x-rays are taken immediately. Signed permission is, of course, required. It is necessary to shave the patient's head and to administer an anesthetic to perform a ventriculogram. For this reason, the procedure is often postponed until the diagnosis has been established by other means. It is usually performed immediately before the major operation for removal of the tumor. In such cases, the purpose of the ventriculogram is to determine the location of a brain tumor which is already known to be present.

During the preoperative period when the diagnosis is being established by the methods described, the care of the patient must be adjusted to his needs and to the nature and degree of his symptoms. His nutritional needs should be met by means of a normal well-balanced diet if his condition warrants it. If paralysis, mental confusion, or blindness makes it impossible or difficult for the patient to feed himself, he should be fed by the nurse. Gavage may be resorted to if the patient is not alert enough to chew and swallow.

Attention must also be paid to the patient's fluid intake. It is usually limited to about 1500 cc in 24 hours—sufficient to prevent dehydration, but not enough to cause cerebral edema. If fluids cannot be taken by mouth, they may be given parenterally. However, intravenous or subcutaneous infusions should not be used when any other method of feeding is practicable, because not all the essential nutrients can be supplied parenterally. When administration of parenteral fluids is necessary, they should be given slowly (40 to 60 drops per minute), and in divided doses (e.g., 500 cc every eight hours), in order to minimize the danger of increasing intracranial pressure.

Intake and output of fluids should be recorded so that it can be seen whether or not the patient is consuming the required amount of fluids, and whether the urinary output is being maintained. The latter is important because either incontinence or retention of urine may occur in patients with brain tumors. Insertion of an indwelling catheter provides a satisfactory solution to either problem, and has the further advantage of facilitating the measurement of fluid output. If the output is considerably less than the intake, dehydrating measures are sometimes used in order to decrease the pressure within the cranial vault.

Laxatives should be used if necessary to provide for regular elimination by bowel. Enemas are usually not given because the straining associated with expelling an enema increases intracranial pressure.

Some medication is generally required during the preoperative period for the relief of pain. Codeine and aspirin are the drugs most commonly prescribed. Although the pain may be very severe, morphine is used neither preoperatively nor postoperatively because it depresses the respiratory center, increases intracranial pressure, and masks the state of consciousness.

If the patient is unconscious, semiconscious, or paralyzed, he requires special skin care to prevent pressure sores. His position should be changed frequently, the "danger spots" (back, buttocks, heels, and elbows) should be massaged each time he is turned, and the bed should be kept dry and free from wrinkles and crumbs.

Protection from injury is another important aspect of the preoperative care

Correct posture for spinal tap: the knees are drawn up, the head is down.

Aseptic conditions are carefully observed while spinal tap is being done.

of the patient with a brain tumor. If the patient's symptoms include paresis, blindness, or anything else which might predispose him to injury, precautions should be taken to prevent falls, bumps, etc. The patient should be helped in and out of bed, and should be accompanied by a nurse or attendant when walking. If the patient is confined to bed, crib sides may be used as a precautionary measure against falls.

Psychological care is of utmost importance for the patient with a brain tumor. If he is conscious and rational, he is likely to be depressed, fearful, and apprehensive. It requires great tact and understanding on the part of the nurse to reassure the patient and inspire him with confidence without being untruthful or unreasonably optimistic. Psychological help must be given to the patient as the need arises, and must be suited to his personality, his intelligence, and his circumstances. The nurse should carefully avoid discussing the patient's condition within his hearing, even if he is apparently unconscious, as he may be able to hear and understand although unable to respond.

It is essential that spiritual assistance be given before brain surgery. The patient should be visited by a priest, minister, or rabbi, and should have ample opportunity to receive whatever religious ministrations are required or desired. Besides its intrinsic value, spiritual care of the patient at this time inspires him with confidence in the providence of God and willingness to conform to the designs of One Who is infinitely wiser than himself. Such a favorable change in the patient's attitude is of great help in promoting the mental rest which is an important phase of preoperative care.

When the diagnostic work has finally been completed and the operation for removal of the brain tumor is scheduled, the patient's head must be shaved. This is usually done by a barber because he is less likely to nick the scalp than is someone with less experience. The hair should be placed in a large envelope and saved, so that, in the event of the patient's subsequent death, it can be given to the funeral director to be used in preparing the deceased for viewing.

Because of the serious nature of the operation, it is particularly important to have an operative permit signed. The patient may do this himself if he is rational and capable of taking the responsibility; otherwise, his nearest relative signs the permit.

The type of preoperative medication which is prescribed depends largely on the patient's state of consciousness. If he is comatose, preoperative medication may be omitted entirely, or atropine or scopolamine may be given to decrease the secretion of mucus in the mouth and respiratory tract. If the patient is conscious, codeine may be given with one of the aforementioned drugs to allay excitement and promote relaxation.

When the patient is about to be taken to the operating room, his family should be allowed to see him and talk to him. It is advisable to tell the members of the family that the patient will be in the operating room for a long time, so that they will be prepared for the seemingly interminable period of waiting. Every possible consideration should be shown to them during this time. Giving them information about the patient's condition and the progress of the operation, and seeing that they go out for lunch or are served trays, according to the policy of the hospital, will be greatly appreciated by them.

Because the patient will require con-

The safety of the patient with a brain tumor is an important consideration before and after surgery. While the patient is confined to bed, side rails are used and other precautionary measures taken to prevent accidents.

stant, skillful nursing care after surgery, private duty nurses should be in attendance for at least a few days. It is imperative, however, that these nurses be skilled and experienced in caring for patients who have undergone brain surgery. If such nurses are not available, or if private duty nurses are not within the financial reach of the patient, the wisest course is probably to have the patient cared for by the staff nurses.

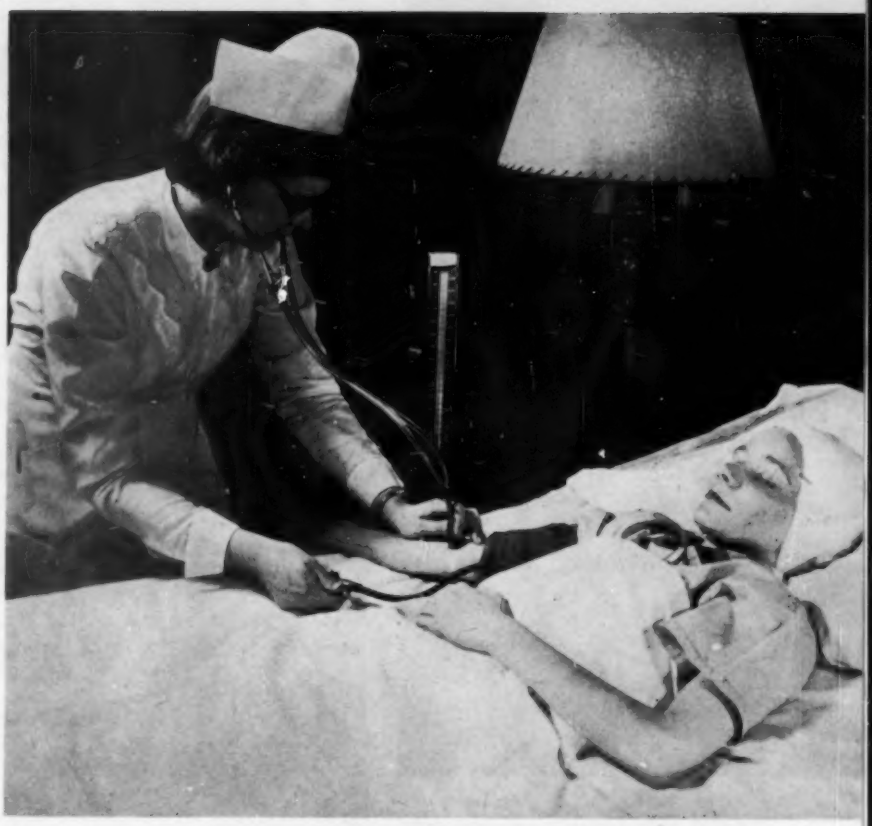
While the patient is in the operating room, the bed is prepared as for any other operative patient except that blankets are omitted in order to minimize the danger of hyperthermia.

On his return from surgery, the patient is placed on his unaffected side with particular care to maintain an open airway since obstruction to the airway increases intracranial pressure. After the patient reacts from the anesthetic, the head of the bed is elevated in order to decrease cerebral congestion by facilitating venous drainage. The patient is moved from side to back to side every two hours to prevent respiratory complications and relieve pressure areas. He is not allowed to lie on the affected side because direct pressure on the operative site may cause the bone flap to be pushed in, thus damaging the underlying brain tissue.

Observation and recording of symptoms assume new importance after surgery. The patient's life may depend on the alertness of the nurse in reporting untoward symptoms to the neurosurgeon so that he can institute treatment before irreversible damage has been done.

Changes in the vital signs are symptomatic of serious postoperative complications. Therefore, the pulse, respirations, and blood pressure should be checked every 15 minutes until stable, then every hour for at least 48 hours. The temperature, which is to be checked at hourly intervals for 48 hours, is taken rectally until the patient's condition warrants taking it orally. Other symptoms to be watched for are weakness, paralysis, tremors, convulsions, vomiting, and changes in the state of consciousness.

The vital centers which control body temperature, pulse rate and rhythm, respiratory rate, and other functions are often disturbed by manipulation of the brain during the operation or by postoperative edema. The symptoms resulting from such disturbances may be extremely dangerous and may eventuate in the patient's death. One such symptom which occurs rather commonly is hyperthermia. In order to prevent this, the patient is covered with only a sheet after the operation. If his temperature rises to 102 degrees F., tepid sponge baths are given. If it is between 102 and 104 degrees, ice bags are applied to the head, axillae, and groins. If it mounts to 104, an ice pack is applied. This is done by covering the patient with chipped ice from neck to feet with only a sheet between his body and the ice. The rectal temperature is checked every 15 minutes while the pack is being given, and the ice is removed when the temperature drops to 100 degrees F. The program followed to control central hyperthermia varies according to the preferences of the neurosurgeon, and may sometimes include the use of electric fans and the administration of ice water enemas.



A change in blood pressure may indicate some postoperative complication. Pressure readings are taken frequently during the immediate postoperative period.

Increased intracranial pressure is another serious complication which requires prompt and energetic treatment. A slow bounding pulse with a rise in blood pressure usually gives evidence of this condition. It is treated by spinal tap or ventricular tap for withdrawal of cerebrospinal fluid; intravenous administration of hypertonic solutions such as 50 per cent glucose to withdraw fluid from the tissues; and oral or rectal administration of magnesium sulphate to further dehydrate the patient.

Codeine and aspirin are usually ordered for relief of postoperative pain. Restlessness may be controlled by the administration of chloral hydrate and sodium bromide. Phenobarbital is pre-

(*Continued on page 43*)

The patient is set on a self-help routine as soon as it becomes feasible.

A Home away from home

How to insure the best in comfort and care when the elderly, chronically ill and convalescent patients are institutionalized.

by Alice Sale Nelson,
L.N.P., President, Area Five,
Practical Nurse Association of Virginia

MRS. Plyler's Nursing Home was established in Richmond, Virginia more than a quarter of a century ago when two sisters, who were also practical nurses, realized a long-existing desire to devote their services to the care of the infirm and the chronically ill.

Kate E. Plyler and Mary Ingram Clark admitted their first patient in a rented apartment. As the number of patients increased, it became necessary to rent the entire house. Every year saw progress and expansion, but the sisters continued to stress "home atmosphere in addition to intelligent care." Practically all the profits were turned into improving facilities for both patients and employees, and before long the home was equipped to accept also convalescent patients who no longer needed the hospital but were not quite ready for home care.

In 1947 Mrs. Plyler passed away. Because of the incapacity of Mrs. Clark, the supervision of the nursing home was taken over by Gene Clark Regirer, niece and daughter of the original founders, and herself a licensed practical nurse. At that time the home was moved to a large residence a short distance away, and in 1952 another wing was added, increasing the capacity to fifty beds. The home provided employment for some fifty people, including thirty special and general duty practical nurses, nurses' aides, and four orderlies.

As the home grew in size so did the problems of administration, bookkeeping, cooking, maintenance, storage, and personnel. The problems were adjusted one by one and the current picture of management that emerges is as follows:

Upon admission the patients are examined by their own physicians under whose supervision they remain while in residence. Charts are kept on all patients and physicians' orders are meticulously carried out.

Medicine cabinets, whether in the central supply room or on the floor, are compartmentalized and labelled with the patients' names to eliminate the hazard of misadministering medication.

Food is carefully prepared and served on individual trays in the patients' rooms. The dietitian tries to observe the wishes of each patient and by a variety of texture and color makes the food tempting and appetizing as well as nutritious. Where necessary, special diets or formulae are prepared. Sanitation is

The room furnishings meet not only decorative but utilitarian standards. The patient's happiness and safety are assured and nursing care is greatly facilitated.

maintained with the aid of modern equipment.

Mrs. Regirer acts as administrator, business manager, personnel director, interviewer and bookkeeper. In her absence, the superintendent of nurses takes over, and she in turn has a relief superintendent to assure continuity of supervision. The night supervisor and her relief plus the dietitian complete the supervisory staff. All the supervisors are licensed practical nurses. They oversee the other personnel, assign duties, order and supervise administration of treatment in accordance with the physicians' advice, and issue linen and supplies. By making frequent rounds day and night they see that each patient receives proper care and every comfort possible. The dietitian is in charge of fourteen employees in the food and housekeeping departments.

After completing one year of service, nurses' aides receive a cap with distinctive insignia. As a matter of comity, no member of the staff is permitted to wear a uniform which might misrepresent her status. Service pins are awarded for length of service.

Efforts are also made to insure the well-being of employees. An intercommunication system and a laundry chute save the nurses many unnecessary steps. Because of good working conditions and congenial relationships, there is practically no problem of drifters. Supervisors rarely ask a subordinate to do something that they themselves would not be able or willing to perform.

The stability of the employment situation has a salutory effect on the patients. There is no institutional regimentation and family relationships prevail. The supervisor cheerfully accepts responsibility for the personal problems of her employees and feels compensated by the high morale that exists.

Modern furnishings and equipment not only add to the comfort of the patients but facilitate nursing care. Advanced sterilizing apparatus assures the staff that instruments and hypodermic equipment are in proper working order.

All furniture, matched in a pleasant and restful beige color, is fireproof. Beds are adjustable to high and low level. Formica tops on tables, overbed tables, bedside cabinets, desks and dressers assure ease of cleanliness. Beds are equipped with safety sides. Where required, end guard-rails are available for further safety of the patient. Floors are covered with vinyl slip-proof tile.

The rooms are light and cheerful, decorated in pleasant and restful colors. An attempt is made to avoid overcrowding so that only one large room has four beds; there are eight double rooms and twenty-nine single ones. Most rooms have individual bathrooms. Air-conditioning is supplied for many of the rooms during the summer, and modern heating equipment provides plenty of warmth in the winter.

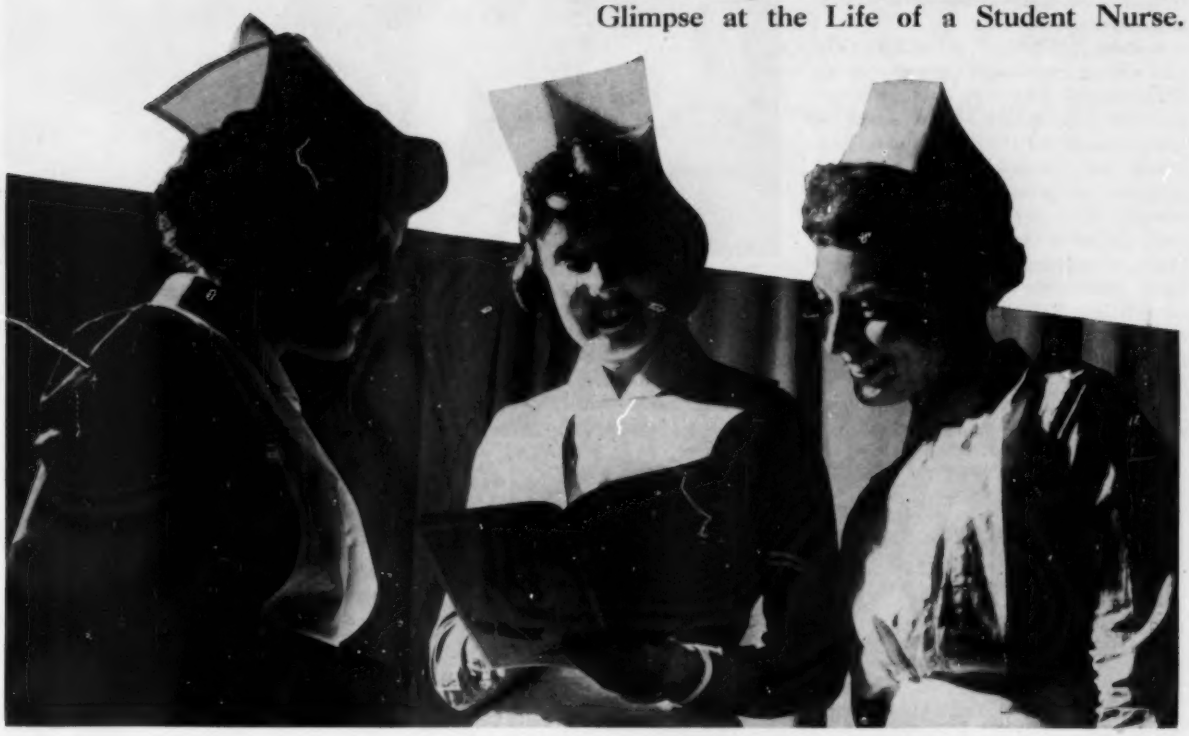
A large living room and library, richly carpeted and curtained, with a 27-inch television set, is the social center for gossip, amusement, or rest. A variety of national magazines adds to the patients' pleasure.

Porches and lawns contribute to the well-being of those patients who can bask in the sun or go for a walk. The ambulatory patients are frequently taken to church or for automobile rides to local points of interest by their families.

Methods of institutional efficiency have been applied but they are not permitted to conflict with the tradition that an institution of this sort must be a home away from home.

The library is a common meeting ground for those seeking television entertainment, a magazine, or merely the comfort of a soft chair in pleasant surroundings.

Student Nurses for a Day—Girls Interested In a Nursing Career are Afforded an Intimate Glimpse at the Life of a Student Nurse.



Recruiting Takes A Forward Step

by Anne Middlemiss, R.N., Director of Nursing Service and Nursing Education, Middletown Hospital, Middletown, Ohio

"HOW would you who are considering nursing as a career like to spend a night as guests of our student nurses and observe the nursing functions in the hospital on the next day?" The question was put to a group of senior high school girls, members of the local Nightingale Club, at a regular meeting over a year ago. The eager faces of the girls gave us the answer. From this grew our plan for "Overnights."

Acting on this response of acceptance, the faculty discussed possible plans at its next weekly meeting. When the sleeping accommodations were investigated it was agreed that we could handle ten to sixteen students at a time. Tentative plans were formulated and presented to the entire student-nurse body for opinion. The proposal was enthusiatically accepted as a "wonderful idea." Dates were then chosen with careful consideration to possibly conflicting school activities. Student-nurse committees were appointed to plan the program for the night of the guests' arrival. The faculty determined what the observation should include and how we were going to obtain the high school students.

Earlier in the year a conference had been held with the officers of the Alumnae Association of the School of Nursing, and we invited their cooperation and support for student recruitment. At that time the list of alumnae was checked and a recruitment captain was appointed for each area within a 100-mile radius. In the main these people were nurses who had married and were residing in smaller communities.

The captains were invited to attend a luncheon as the guests of the Hospital Board at a local hotel. At this meeting the President of the Board spoke briefly about the building program which would add 110 more beds as well as ancillary services to the already existing 150-bed general hospital. The Director of Nursing then presented the plan for their participation in recruitment. Each recruitment captain was asked to contact her local school superintendent for an opportunity to talk with the junior and senior girls about nursing. She was armed with packets containing general recruitment information for nursing as well as specific publications from the Nursing School. At these meetings the captains told about the "Overnights" and collected the names of the senior girls who wished to attend. Each applicant for an "Overnight" was sent a card so that she could indicate her first and second-choice dates for an "Overnight" invitation.

The girls arrived at the nurses' residence at 7:00 P.M. on a Friday night and were greeted by the student hostesses in uniform. They were shown to their rooms and issued scrub dresses for their Saturday morning hospital observation.

A miniature paper nurse's cap modeled after the one worn by the students was pinned to each guest's blouse. The cap indicated the name of the guest student and where she was from.

During the period of arrival those who wished were taken on a tour of the Hospital and School by student nurses. By 8:00 P.M. all had arrived and the visits through the Hospital, Nurses' Residence and School were completed. Whatever program was planned for the evening then began. This varied on each occasion and included movies, games, group-singing, and whipping up some home-made ice cream and popcorn balls. Refreshments were served around 9:30 P.M. and all retired to their rooms by 10:30 P.M. The post-retirement period provided a free and relaxed environment for the many questions the girls had about the life of a student nurse.

Two recruits register for their "Overnights". The registrar and her inanimate counterpart present a pretty good picture of how they would appear in uniform.

Questions and answers are exchanged as a nurse helps the guests unpack.

Chapel at 6:30 A.M. Saturday saw the guests, dressed in their scrub dresses and wearing their souvenir miniature caps, participating with the student nurses in their regular daily service. Breakfast followed in the hospital cafeteria. The student nurses left for their assigned duty areas while the guests adjourned to the nurses' lounge. At 7:15 A.M. volunteer members of the Alumnae Association joined the group. They were introduced to the guests and each one assigned to accompany four to six girls during the morning's observation program.

At this conference the guests were told by the Director of Nursing what the plan would be for the morning:

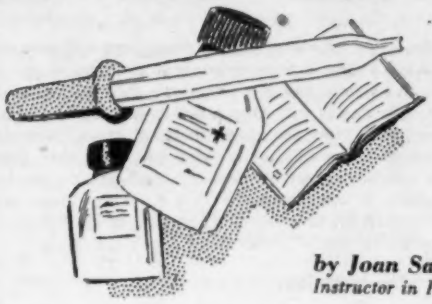
- Fifteen minutes' observation through the glass window of the newborn-nursery.
- Fifteen minutes' observation through the glass window of the operating room.
- One and one-half hour observation on a general medical-surgical floor.
- Fifteen minute mid-morning break for nourishment in the hospital conference room.
- Visit to Children's Department.
- One and one-half hours on the second Adult Floor.
- Luncheon in the cafeteria with student nurses and Alumnae volunteers.

During observation periods on the various floors the Alumnae member always remained with the group, pointing out the pertinent phases of patient-care. The patients are most interested in the program and seem to enjoy having the girls. The guests observed bathing, bed-making, feeding, simple dressings and treatments, oxygen tent therapy, gastric suction, and intravenous drip.

After luncheon the girls were invited to meet again with the Director of Nursing for a question period. Without exception each girl expressed a deep and sincere appreciation for this experience. By 1:00 P.M. all had returned to the nurses' residence where they changed, packed up, and left for home.

It is felt that this "Overnight" experience has resulted in an increase of about one-third the previous total class enrollment. The plan has been in effect for only one year but at the present time indications are that these visits will again result in a larger class this fall.

Each recruit is issued a nurse's "cap". Although this headgear is made of paper, it is a faithful replica of the caps worn by the student nurses in the School.



Advances and Trends in Drug Therapy

by Joan Sarvajic, R.N.
Instructor in Pharmacology, Bellevue Schools of Nursing, New York City

Antihistaminic Drugs

SINCE 1945 a confusingly large number of antihistaminic drugs have been introduced commercially and advocated for the symptomatic management of a wide variety of allergic disorders. Although comparatively new, they already hold a secure place in the armamentarium against allergic manifestations since they exert a specific action against histamine and thus are effective in preventing or ameliorating the symptoms induced by the liberation of this substance in the tissues.

The Role of Histamine in Allergy

Dale and Laidlaw first noted the marked similarity between the symptoms which follow the intravenous injection of histamine and those of allergic reactions. In both conditions there is contraction of the smooth muscle of the bronchioles, vascular system, intestine, uterus; dilation and increased permeability of the capillaries and swelling in the skin and mucous membranes; stimulation of the lacrimal, nasal, pulmonary, and digestive secretions; and an action on the nerve endings in the skin producing pain and itching. Inasmuch as histamine, or at least its precursor histidine, is widely distributed in the tissues it seems logical to assume that the symptoms of allergy might be caused by the liberation of histamine in these conditions.

The mechanism of allergic reactions may be ascribed to the interaction of the antigen (or sensitizing constituent of the allergen) with a sensitizing antibody (or reagin). The reagin is present in the body of the allergic person, particularly in the "shock tissues" where symptoms appear. Fixed antibodies are localized in the "shock organs" which, on renewed exposure to the sensitizing antigen, elicit an antigen-antibody reaction where there is a release of histamine and probably other substances in the shock tissues with the production of symptoms characteristic of the allergic response.

The Histamine Antagonizing Agents

In 1933 Forneau and Bovet showed that certain phenolic ethers were capable of inhibiting or counteracting the action of histamine. In 1937 Staub and Bovet further confirmed these findings by alleviating the symptoms of histamine shock that was deliberately produced in guinea pigs. In 1939 Staub reported a compound with an ethylenediamine radical with similar properties. These drugs, while exhibiting a decided antihistaminic effect, were toxic and could not be studied in man. Then in 1942 Halpern introduced for clinical use in France a chemically related drug under the trade name of "Antergan." In 1944 a less toxic preparation, pyranisamine maleate (or "Neo-Antergan) was reported and in 1945 tripelennamine (or Pyribenzamine) and diphenhydramine (or Benadryl) were introduced in this country.

Subsequently a number of histamine antagonists were introduced on the market: diphenhydramine and aminophyllin (Hydrillin), phenindamine (Theophorin), Diatrif, prophenpyridamine (Trimeton), doxylamine (Decapryn), chlorothen (Tagathen), methapyrilene (Thenylene), histadyl, thonzylamine (Neohetramine), and antazoline (Antistin). The effectiveness of these drugs is apparently dependent on a certain chemical grouping since most of them contain the diamino radical.

The Nature of Antihistaminic Action

Antihistaminic action is by no means entirely clearcut and numerous possibilities have been proposed. Most of the earlier studies indicated that the antihistaminic compounds interpose themselves protectively between histamine and the cells in the "shock organs," probably through absorption onto the cells.

Haley and Harris's recent findings at the University of California reveal the likelihood of vasoconstrictor action on the precapillary sphincters in opposition to the vasodilator action of histamine. This would mean that histamine and the antihistaminics compete for the same site of action. It has been alleged that the amount of histamine in the blood increases during antihistamine therapy and perhaps antihistaminic activity consists at least in part in liberating tissue histamine.

Therapeutic Uses of Antihistaminics

These drugs are not curative and their use does not diminish the importance of continued research for the etiologic factor in every allergic situation. But they frequently induce symptomatic relief, especially when the symptoms resemble the vascular and mucous membrane alterations effected by local application of histamine. Antihistaminics have been used more or less successfully in urticaria and angioneurotic edema, seasonal hay fever, and spasmodic bronchial cough. There has been some alleviation of symptoms in persons hypersensitive to cold; in gastrointestinal allergies although the evidence is not clearcut; in edema of serum sickness; and in the pruritic phase of antibiotic, sulfonamide, and other drug reactions. Patients sensitive to liver extract may be greatly relieved. These drugs are often useful in the prevention and treatment of systemic reactions to allergenic substances injected during hyposensitization although the more severe reac-

tions are usually better controlled by epinephrine.

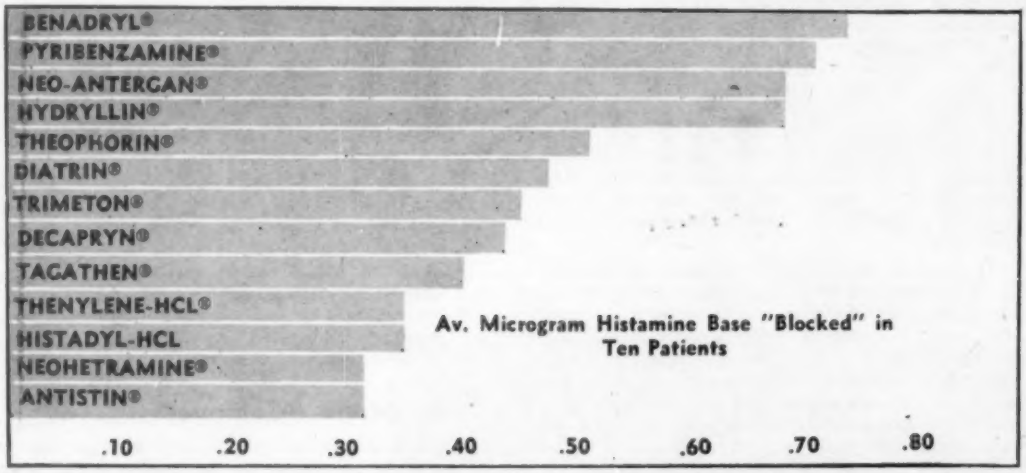
The antihistaminic compounds have been advertised widely to the laity as preventives and curative agents of the common cold. There is no statistical evidence however to support these claims. The common cold is a catarrhal affection of the respiratory mucous membrane which may result from allergic reactions, bacterial and viral infections, and possibly from psychosomatic factors. Obviously the antihistaminics could exert no action in preventing or curing the common cold except as they might mitigate the effects of allergic rhinopathy.

Methods of Evaluating Antihistaminics

In order to bring some semblance of order to the problem of "too many antihistaminic agents" an objective method of measuring their activity in man is essential. In 1947 Cohen and his co-workers, using histamine iontophoresis, showed that the histamine whealing threshold of the skin was altered by the administration of Benadryl.

Utilizing a comparable method (serial dilutions of histamine base), Steinberg, Perry, and Le Van reported in 1950 a comparative evaluation of thirteen antihistaminics. The initial threshold is determined by the highest dilution of histamine base producing diffuse punctate whealing at the site of the positive electrode. The drug to be tested is then administered orally and the threshold again determined one and two hours later. The difference between the initial and subsequent readings is the measure of the antihistaminic activity of the test drug.

The comparative antihistaminic activity of the various drugs is indicated in the graph below:



It will be noted that Benadryl, Pyribenzamine, and Hydrillin show the greatest antihistaminic activity, while Antistin, Neohetramine and histadyl showed the least. Between these two groups were Theophorin, Diatrin, Trimeton, Decapryn, and Tagathen. It is important to recognize that Hydrillin contains one part Benadryl and four parts aminophyllin. Previous experimentation had indicated that aminophyllin itself had little antihistaminic effect and therefore the activity of Hydrillin is considered to be due to the Benadryl component. Chlorprophenhydramine or Chlor-Trimeton was also tested although at the date of experimentation it was not yet commercially available. This drug had practically no effect on the histamine threshold after oral administration of the recommended 2 mg. dose.

In the course of testing, it was noted that different subjects varied widely in their response to the same drug. Interestingly enough, in some individuals the antihistaminics are not effective at all. One possible explanation is lack of absorption from the gastrointestinal tract. However, some subjects demonstrate no response even after intravenous administration of Benadryl, indicating that lack of response is not necessarily due to faulty absorption. This is one of the fundamental problems in antihistaminic therapy which needs further study and clarification.

Toxic Manifestations

Toxic reactions and undesirable side-effects following the use of the histamine antagonists are not uncommon. In the use of Pyribenzamine and Benadryl, the two drugs with which there has been most experience, there is a 10 to 50 per cent incidence of drowsiness, dizziness, dryness of the mouth, and gastrointestinal disturbances. These are the outstanding manifestations of toxicity from the majority of the antihistaminics. Persons taking them should be careful about engaging in activities which require strict attentiveness or working where precision timing and accuracy are necessary.

The incidence of undesirable side-actions is fully as difficult to evaluate as therapeutic efficacy. Available studies indicate that in all probability Benadryl most frequently causes excessive drowsiness and Pyribenzamine most often induces gastrointestinal disturbances. Other side-reactions seen less frequently are faintness, headache, blurring of vision, apprehension, confusion, tremulousness, paresthesias, urinary frequency, difficulty of micturition, and insomnia. Reactions seem more likely to accompany use of Benadryl, Pyribenzamine, Hydrillin, and Neo-Antergan than Antistine, histadyl, Neo-hetramine, or Theophorin. Toxicity of the newer drugs has not been thoroughly investigated.

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DI-PARALENE — ANTIHISTAMINIC

DESCRIPTION: Di-paralene hydrochloride is 1-p-chlorobenzhydryl-4-methylpiperazine hydrochloride.

ACTION AND EFFECTS: This is a new synthetic drug, of low toxicity and relatively prolonged action compared with other antihistaminic drugs. In two series of experiments with human volunteers, an inhibitory effect on the formation of flares following the application of histamine by a standardized scratch test could be demonstrated for 24 hours or even longer, whereas antihistaminic drugs of the usual type fail to inhibit flare formation after 4 to 6 hours. In clinical tests on patients with urticaria and hay fever, a substantial number of subjects reported relief for 24 hours or more. This prolonged action is presumably attributable to the molecular structure of the drug.

USES: Di-paralene has been found effective in a variety of allergic conditions in which the release of histamine may be a prime factor in the symptom-complex. These include urticaria, non-seasonal vasomotor rhinitis, hay fever, asthma, and various types of itching dermatoses. Objectively and subjectively, clinical results are better than or comparable to those provided by other antihistaminic agents in use.

PREPARATIONS: Di-paralene is marketed in tablets of 25 and 50 mg.

DOSAGE AND ADMINISTRATION: The initial adult dosage of Di-paralene hydrochloride is 50 mg. three times daily. If a satisfactory response is obtained an attempt should then be made to reduce it to two or one 50 mg. doses daily. A single daily dose should be timed so that it is given about two hours before the expected onset of peak symptoms. When no one period of the day is associated with peak symptoms, 50 mg. may be given morning and evening. In more refractory cases the total daily dose may be increased to 200 mg. Such dosages should be used only for short periods of time, with the patient under close observation.

TOXICITY: In some patients Di-paralene may cause side-effects as seen with other antihistaminic drugs, but in the dosage recommended these are reported to be relatively mild. The most common side-effect reported is drowsiness. In patients receiving higher dosages, drowsiness, lightheadedness, gastrointestinal irritation, and dryness of the mucous membranes were reported in a few instances. In general, the incidence of side-effects has been less than that usually expected from other drugs of this type.

PRECAUTIONS: Pending further experience the drug should not be continued over periods longer than three months. As with all new synthetic drugs, patients should be observed at regular intervals by the physician and nurse and should be checked for any unusual side-effects. The physician and nurse should watch for any signs which might be attributed to changes in blood-forming organs, liver, or kidneys. No impairment of liver function has been reported in patients receiving Di-paralene. However, in an experiment on young rats some liver damage was demonstrated. This emphasizes the necessity for careful clinical supervision of all patients receiving a new synthetic material over extended periods of time.

ISOPROPYLARTERENOL SULFATE — SYMPATHOMIMETIC

DESCRIPTION: Alpha-(isopropylaminomethy)-protocatechuyl alcohol, also known as Norisodrine, is a synthetic amine having sympathomimetic properties. It is chemically related to epinephrine and ephedrine.

ACTION AND EFFECTS: Isopropylarterenol effectively dilates the bronchi and coronary vessels, and relaxes the jejunum. It also has cardiovascular effects which are somewhat dependent on the dose administered and the route of administration. Tachycardia, increased pulse pressure, and precipitate falls in blood pressure occur.

USES: Isopropylarterenol is more effective than epinephrine for symptomatic treatment of conditions in which bronchial spasm is a prominent feature. It produces a significant increase in vital capacity, relieves asthmatic dyspnea, and abolishes the blood pressure fluctuations characteristic of asthma. There is little evidence of "fastness" to the drug. It has proved effective in many asthmatic patients who are "epinephrine-fast" and in those who can not obtain relief from such drugs as theophylline, iodides or ephedrine.

PREPARATIONS: Isopropylarterenol is marketed as Norisodrine Sulfate Powder, 10 per cent and 25 per cent, for oral inhalation, in aerohalor cartridges containing 100 mg. of powder.

Norisodrine Sulfate Solution 1:100 is intended for use in a hand nebulizer or by oxygen aerosolization.

DOSAGE AND ADMINISTRATION: For mild or moderate acute attacks of bronchial spasm, two to four normal inhalations of the 10 per cent Norisodrine Sulfate Powder, through the aerohaler, is recommended. The patient should be cautioned not to take a forced deep inhalation. If there is no relief in two to five minutes, the dose may be repeated, and continued at not less than ten-minute intervals until relief is obtained or undesired side-effects supervene. In severe asthma treatment should be initiated with the 25 per cent powder.

Norisodrine Sulfate Solution 1:100 may be used as an aerosol to treat or prevent an acute asthmatic attack and for maintaining symptomatic relief in chronic asthma. This solution must not under any circumstances be dropped into the nose. It is meant for use by aerosol therapy or in a nebulizer. If a nebulizer is used, three to nine drops are advised for severe asthma. The bulb is squeezed twice during each inspiration. Ten to thirty minutes are allowed to elapse before the dose is repeated.

TOXICITY: Dizziness, palpitations, nervousness and tachycardia may occur as toxic manifestations. Cardiovascular effects including coronary insufficiency and myocardinal impairment can result from overdosage.

PRECAUTIONS: Particular caution should be taken in the use of Norisodrine by patients with histories of coronary artery disease or myocardial insufficiency. Patients should be instructed to discontinue the drug at the first sign of palpitations, lightheadedness, or syncope. If these symptoms should develop during or soon after the preparation has been administered as an aerosol, the patient must wash the mouth and throat with water. If necessary he should lie down and loosen any tight clothing. Usually, mild reactions will pass off in a few minutes. In a severe reaction (palpitation, hypotension, collapse, substernal pain) bed rest, oxygen, sedatives and other general treatment are given as indicated.

Norisodrine should not be used simultaneously with epinephine or ephedrine as it has a similar action on the heart. However, it may be used alternately with these drugs.

THEOPHORIN — ANTIHISTAMINIC

DESCRIPTION: Theophorin is an antihistaminic drug which is chemically 2-methyl-9-phenyl-2,3,4,9-tetrahydro-1-pyridindene hydrogen tartrate.

ACTION AND EFFECTS: Theophorin shows moderate histamine-blocking efficacy. It is described as being nonsedative. In fact, it has a mildly stimulating effect on some patients.

USES: Theophorin is used to mitigate symptoms in hay fever; allergic rhinitis (seasonal and perennial); vasomotor rhinitis; bronchial asthma (seasonal, extrinsic, intrinsic); atopic dermatitis, allergic eczema, angioneurotic edema; drug reactions; serum sickness; other allergic disorders; and Parkinson's disease.

PREPARATIONS: Theophorin is marketed in various forms. In tablets of 25 mg. each. As a syrup—10 mg. of the drug per teaspoonful. Theophorin-AC tablets (containing also aspirin, acetophenetidin, and caffeine) for symptomatic relief of the common cold. Theophorin Expectorant (with codeine, papaverine, ammonium chloride, and chloroform) for control of a dry hacking cough. Theophorin Ointment (5 per cent in a carbowax base) for antipruritic therapy. Theophorin Lotion (in 2 and 5 per cent strength) for sunburn.

DOSAGE AND ADMINISTRATION: 25 to 50 mg. of Theophorin taken one to three times a day is adequate dosage in most cases. In Parkinson's disease a daily dose of 200 to 400 mg. may be required, supplemented by other medications such as belladonna alkaloids or synthetic antispasmodics.

TOXICITY: The incidence of unpleasant or dangerous side-actions from Theophorin is low. Nausea and vomiting are infrequently reported and do not require discontinuance of therapy in most instances.

PRECAUTIONS: It is important for the nurse to remember that Theophorin, in contrast to most antihistaminics, has mildly stimulating effects on some patients and when taken late in the evening may cause insomnia. The concomitant use of a mild sedative-hypnotic is recommended in such cases.

Paradoxically, the antihistaminics themselves sometimes cause allergic reactions and may even aggravate existing allergic manifestations, especially in asthmatic patients. If this occurs, the nurse should be prompt in reporting such symptoms since another antihistaminic might be substituted.

There is no antidote for the antihistaminics. The use of histamine to combat their excessive effects is irrational because their toxic action is not related to their antihistaminic action. In combating convulsions, if such drastic symptoms should occur from this antihistaminic, the short-acting barbiturates or even ether may be indicated. Phenobarbital may be preferred because it has greater anticonvulsant potency than have the short-acting barbiturates.

DRAMAMINE — ANTIHISTAMINIC

DESCRIPTION: Chemically Dramamine is beta-dimethylaminoethyl benzohydryl ether 8-chlorotheophyllinate.
ACTION AND EFFECTS: The antihistaminic potency of Dramamine was determined by protection studies against a standard lethal mist of histamine. Dramamine is one and one-half times as effective as the ether base of the compound (base content measurement). It has relatively low spasmolytic activity, may cause a transient fall in blood pressure, and a brief stimulation of respiration.
USES: Dramamine is apparently a powerful, nontoxic, prophylactic and therapeutic drug when used to control the symptoms of motion sickness.

Rust and Fosbery, in writing of their experiences as surgeons on the R.M.S. Queen Elizabeth, state that in almost every case Dramamine has caused almost complete disappearance of seasickness.

Strickland and Hahn, were of the opinion that the drug "appears to decrease the incidence of airsickness." Their study was conducted aboard Air Force planes in which Dramamine-protected and placebo-protected volunteers were seated alternately, taken aloft to 5,000 feet and subjected to simulated air turbulence for one hour. These authors reported a protection rate of 71.3 per cent even though the conditions of the experiment placed all the subjects within the sight, sound and odor of vomiting by sick passengers.

Other forms of motion sickness (car and train) are equally well controlled by Dramamine.

Dramaine is also effective in controlling or relieving vertigo in such conditions as Meniere's syndrome, radiation sickness, hypertension, postfenestration syndrome, and labyrinthitis.

PREPARATIONS: Dramamine is marketed in scored tablets of 50 mg. each, and as a liquid, 12.5 mg. per 4 cc. For parenteral use it is available in 5 cc. ampules containing a solution of 250 mg. of Dramamine.
DOSAGE AND ADMINISTRATION: Nausea, vomiting or vertigo may be controlled for about four hours by the administration of 50 mg. of Dramamine orally or rectally and prevented by a similar dose every four hours. A somewhat lesser parenteral dose should be effective in similar conditions. Parenterally, Dramamine should ordinarily be administered intramuscularly although if well diluted it may be given intravenously.

The following schedule should provide relief or prophylactic protection for children: 12:5 to 25 mg. orally two or three times daily for the five-to-eight-year-group; 25 to 50 mg. two or three times daily for the eight-to-twelve-year-group; and 50 to 100 mg. two or three times daily for children over twelve years of age.
TOXICITY: As with many other antihistaminics, drowsiness, dizziness, dryness of the mouth, and gastrointestinal disturbances are occasionally seen as toxic manifestations.
PRECAUTIONS: Patients should be informed of possible untoward effects from Dramamine. The possibility of sedative action should be recognized and patients made aware of the risk in driving a car or working where occupational hazards are present.

Parenteral Dramamine should not be administered intravenously unless diluted. The concentrated solution may exert an irritant action on the veins with resulting sclerosis. No significant irritation from intramuscular injection has been observed in extensive clinical observation.

The Nurse Consultant is the Key Figure In an Industrial Health Program.

A Sound Industrial Health Program

by John F. Welch,
Assistant Treasurer,
The Pond Lilly Co., New Haven, Conn.

TO understand what an industrial executive expects from a nurse consultant requires some knowledge of the duties and the functions of the executive in order to clarify not only what he expects but why he expects it.

It is important to remember that the executive in industry functions within a corporation and as a part of it. He must subordinate his own personal feelings and opinions to corporate policy and formulate his acts and decisions to that policy. He may not act freely as an individual. Even executives on the policy-making level are limited in initiating policies by such factors as the size of the corporation, its financial position, and by circumstances outside of the corporation such as general economic conditions, price levels and the specific market for his own product.

The individual executive's job differs, depending on the type of corporation or company for which he works. In big corporations, departments are staffed by specialists who may deal with only one subject and its related problems. Smaller corporations exist without such luxuries and the executive is faced with a variety of problems including taxes, finance, labor relations, accounting, and others. His competence in any of these fields cannot approach that of the specialist nor does he have specialists within his organization to call upon for advice.

Job circumstances impose another limitation upon him—that of time. Unlike the professional person, the executive must reach prompt decisions on many different matters, and the process of reaching those decisions, though many executives are loath to admit it, is largely intuitive. The imperative demand for quick decisions results in a habit-pattern which, if the executive is successful and isn't fired early in his career, soon becomes crystallized. That habit-pattern accounts for the impatience with other organizations like government and law where long delay in reaching decisions and in completing courses of action is the rule. It accounts, too, for the respect and admiration bestowed upon the "go-getter" and upon "getting things done." The fact that frequently the wrong things get done does not seem to disturb anyone very much.

We now consider the case of a small corporation with approximately five hundred employees, and an executive of that corporation who is considering the installation of a plant medical de-

The information in this article was originally presented, June 1953, at a workshop for Nursing Consultants in Occupational Health, Yale University School of Medicine, Department of Public Health.

partment. What problems does he face and what does he expect from a nurse consultant?

At this point it is well to remember that the executive may have only a vague idea of just what a nurse consultant is. He may have no background knowledge whatever in industrial health or in industrial medical departments. Such deficiencies, especially when they are combined with a light heart, courage, and a passion for getting things done, are characteristics of a formidable person, indeed.

It would be helpful for the executive to know first exactly what the consultant's job is, when he can call upon her for help, what demands he can make upon her time, and under what limitations she works because of ethical considerations. He learns these things as he progresses, but in the beginning he rarely knows what questions to ask. Much of what he should be told about her job may seem elementary to the consultant; it is not so to the executive.

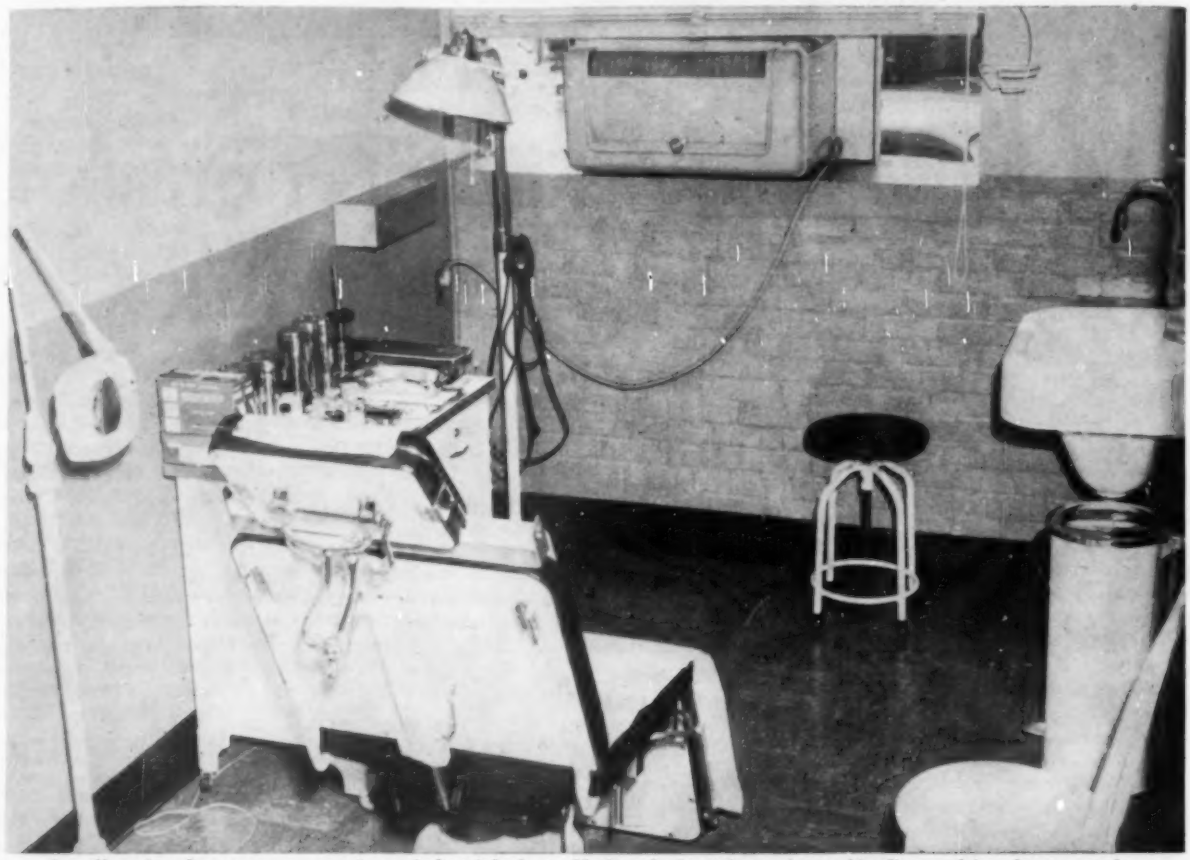
To decide the first problem of whether or not to proceed with an industrial health program, the executive wants to know the answers to two questions: What can it accomplish? What will it cost?

He must know this to reach his own decision and to justify that decision, if it be an affirmative one, to those in his organization who will have a part in the program. He must have the expenditure approved; he must enlist the support of those who will make the plan work — supervisors, foremen, union stewards. He must also be prepared to present the program in such a way that those who may have objections to it can be overruled.

He will learn from the consultant that a properly organized and operated industrial health program can maintain and improve the health of employees; reduce absenteeism and make for more efficient employees; reduce the cost and increase the efficiency of handling compensation cases; discover and control harmful elements in the environment; and provide other benefits. The executive wants more than a mere recital of those accomplishments. From long experience he has become skeptical of panaceas. He encounters many persons who urge schemes upon him for the improvement of his business and of his employee relations. Most of them are without value, and as a result skepticism becomes a habit. The executives must know how and where results have been accomplished. Literature on the subject is not always effective because it is seldom read or studied carefully. Detailed information relating to the accomplishments of plants of comparable size in the same area is the kind of facts the executive wants from the consultant and will be of the greatest value to him in reaching his first decision.

One phase of accomplishment, loosely called "employee relations" should be given greater emphasis. The discontentment of the industrial employee is a problem common to all plants and one which all industry is aware of and constantly striving to solve. Many of those efforts have failed dismally and continue to do so. The reason for the failure is due, doubtless, to our limited knowledge of the causes, which may be rooted far more deeply than we care to admit. But if, as some believe, the genesis of employee discontent is the fact that the human personality cannot be integrated successfully with a machine-paced factory environment, the problem of discontent will not be solved through such devices as the employees' magazine and the company picnic.

Particularly in a small plant where it is possible to give employees free access



A well-equipped emergency room in an industrial plant. If plans had not been thoroughly discussed in advance, such a room might have been rebuilt several times before it could meet the criteria of all concerned with the health program.

to a medical department without a time-clock check on their consultations with the doctor or nurse, the medical department can be used as a counter-irritant to the factory environment. Beyond the treatment of a specific illness or injury and counsel in a specific problem, the employee can gain some measure of satisfaction from being a unique, important individual endowed with human dignity. Although this accomplishment lies in a nonobjective, difficult-to-measure area, the executive should know about it.

The executive wants to know something of the minimum and maximum costs of installation and operation of the medical department. Such figures need not be accurate ones, of course, but approximate ones based on some common factor such as the number of employees. This information is important even in a prosperous company where costs alone would not be a prohibitive factor. In such a situation the executive's decision to proceed may be subject to approval by another executive or a committee of executives and he must submit the matter in such a manner that the balance between accomplishment and cost will be reasonably discernible. Such information, if provided by the consultant, can be of inestimable value to the executive in making an affirmative decision.

Assume now that the executive has reached an affirmative decision and advances to the second phase: the setting-up of a plant medical department. This is a wholly different problem that involves adequate space, medical equipment, a doctor and a nurse. Again, he enters a field in which he has no background knowledge, and with an added risk—it looks easy.

The executive has selected a floor plan from those given him by the nurse consultant; he knows how much space is needed. He has a list of major pieces of equipment required. He plans to interview nurses after the installation is completed. He consults with the plant engineer who prepares a blue-print and proceeds with the necessary lighting, piping and plumbing, painting, and air-conditioning. He consults with the purchasing agent and gives him the list of equipment and furniture. The purchasing agent checks quotations and orders the equipment. In due course the preparations are completed and the equipment and furnishings are delivered. Things have gotten done.

From long experience in industry, the executive is accustomed to differences of opinion on how best to do things and what equipment is best suited to a particular need. But if he has the customary layman's awe of the medical profession, he holds a somewhat vague notion of aloof professionalism, cold objectivity and the rigorous discipline of the scientific method where all is agreement. Holding such a view, it is disconcerting, to say the least, to find that disagreement can exist among people in the medical professions about such curious matters as what part of the body is best suited for turning on water in a sink.

Because he is unfamiliar with such matters, the executive is willing to take advice. He wants to know what is the best and most efficient equipment to provide. By first taking the advice of the consultant, later that of a doctor he has brought in, and finally of the

When the medical department of an industrial plant is properly organized and is operated with a minimum of friction it can become a "counterirritant" to the factory environment and a refuge for the employee in need of treament or counsel.

nurse he has hired, something near the maximum in disagreement has resulted. Such diverse opinions may extend to a variety of things—not only equipment, but furniture and record forms as well. For example, a sink should not be placed in the corner of a room—some persons have objections to such a location, in which event it must be moved This is usually beyond the understanding of the mechanic who has just installed the sink. Single chairs should be provided in the waiting room instead of benches because people do not like to sit next to others whom they may suspect of having something contagious. Such fears are not contemplated in the blueprints, of course, but they may be taken care of simply by exchanging the furniture. Some doctors prefer a record form wider than standard letter-size, but it is not until such forms have been delivered by the printer that the purchasing agent remembers the original equipment list included a typewriter with a standard-size carriage. That is easily remedied by buying a wide-carriage machine, but later it is discovered that some nurses prefer a form printed on a standard letter-size sheet. And so the forms are changed and no real harm done because the company now lists among its assets a typewriter with a large-size carriage. This process continues for some time until everyone seems reasonably satisfied except the purchasing agent who inquires acidly whether the new medical department will, when completed, take psychiatric cases. At this point of relative agreement, another person conceives the very sound, if morbid, idea that if one day the whole thing should catch fire, it would be well to have an extra door to provide egress for the patients and the staff. This is not so simple a process as exchanging a stretcher. It requires knocking out a portion of one wall with violence to the newly decorated area surrounding it, but it is done. Inevitably the time arrives when no one can think of anything else to change and the medical department is ready to operate.

If the nurse consultant had forewarned the executive of such differences of opinion, he might have decided to retain his doctor and his nurse earlier and in conference with them and the nurse consultant tried to reach general agreement.

Again it may seem elementary, but the executive should be told the importance of bringing in a doctor early, the different conditions under which a doctor may be retained, and the retainment plan most practical for his own plant and employee needs.

With respect to employing the nurse, there is much the executive needs to know. The first question is to decide whether the nurse should be employed on a full- or part-time basis. The nurse consultant can detail the duties of a nurse and how her services may be utilized, but it is difficult to judge, even approximately, how much of her time will be required. A more satisfactory answer can come from comparable plants operating medical departments in the area. From their experience he can learn what nursing service they have required and utilized.

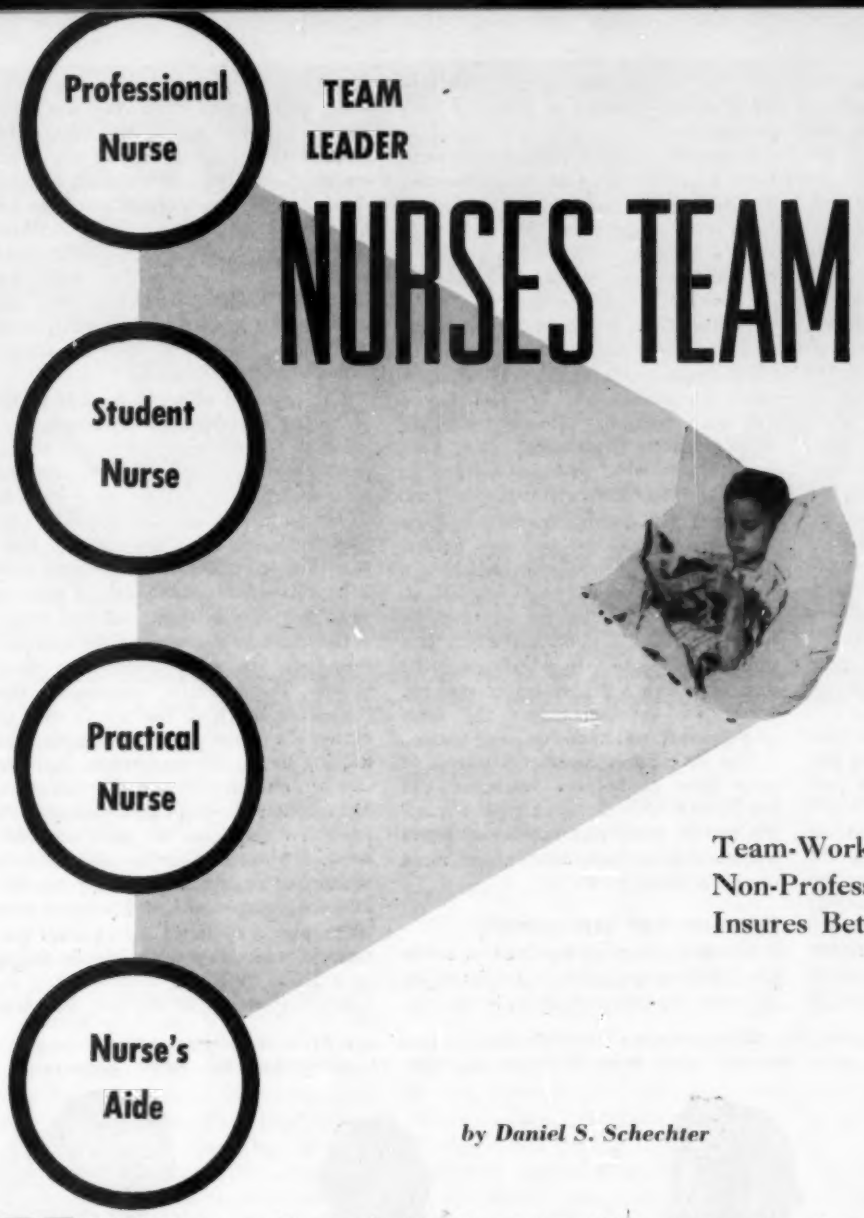
To devise a record system acceptable to everyone it would be wise to pool the ideas of the plant physician, the nurse, the executive and the nurse consultant.

Since it is an unfamiliar field, the executive needs to know what a nurse's salary range should be, what hours she customarily works, whether she is paid overtime, and if so, on what basis. He should be furnished with a source of such information.

Another important question in hiring a nurse is whether to require that she have either industrial training or industrial experience. Such a requirement would seem logical but it is not until one has had experience in the operation of a plant medical department that the full import of such a requirement becomes evident. With the best of intentions, an inexperienced nurse could at least delay, if not harm, the success of a new plant medical department, for its success, particularly at its start, depends upon its acceptance by the employees as a service that is their own. Its value to both management and to the employees lies in the employees' full and free use of the department in confidence that, although provided by management, it has no police or disciplinary function. Only one experienced in industry knows how easily a contrary view of the department could be implanted by the mishandling of only one case. Such an event might produce a result that would take a long time to correct. The executive should be forewarned that sound judgment can only come from a knowledge and an understanding of industrial organization.

Once the medical department is equipped, staffed and in operation, the executives need is to know how well it is operating and how its scope can be increased so that eventually it can reach its fullest potentials. The nurse consultant can help him to appraise the organization of the department. She can suggest the extension of the work of the department to broader aspects of industrial health, and she can serve by informing the executive of new pertinent developments in industrial health.

The executive needs a great deal of help from the nurse consultant. At the same time he learns that she is restricted by ethical considerations, confidences, and the delicate task of not discouraging a prospect by emphasizing difficulties unduly at the start. In the final analysis, the test of her success is whether a medical department and an industrial health program exist today in an organization where yesterday there were none.



NURSES TEAM UP

Team-Work by the Professional and Non-Professional Hospital Worker Insures Better Patient-Care.

by Daniel S. Schechter

HAROLD Carter, age 43, entered a large eastern hospital for removal of a tumor of the jaw. An ambulatory patient, he went through the busy mill in the admitting room and spent the rest of the day in the solarium. He was given routine diagnostic tests in preparation for surgery the next day.

During the night the graduate nurse on the ward observed Carter's restlessness. At 3 a.m. she found him sitting in a bedside chair. In the morning his breakfast was untouched, and she noted that he did not participate in general ward conversation.

When the night nurse went off duty, she reported her observations and another graduate nurse was assigned to make up his bed, instead of the practical nurse to whom this task ordinarily was assigned.

Carter told the graduate nurse about his wife and four children, the home he owned, and his position as a salesman. He said, as he had on his record form, that he had no religious affiliation.

"By the way," he added when she was almost through, "when is your day off?"

"Tomorrow," she replied.

"Then I'd better say goodbye."

"Goodbye?" asked the nurse, trying to draw him out.

"They're operating on me today and if I don't die on the table, I'm sure I'll die shortly afterward."

At a meeting with Carter's physician, the hospital social worker, the practical nurse and the nurse's aide who had been in contact with the patient, the graduate nurse reported her conversation. The practical nurse who had weighed Carter and taken his temperature, and the nurse's aide who had shown him to the sun porch contributed their observations. The report of the night nurse was considered. Examining important questions in preparing Carter for surgery, they asked themselves: What were his feelings about life and death? How did he respond to problems in normal life? What reaction did he have to his tumor growth? Did he think it cancer? If so, did he think death must follow? Did he anticipate a change in his physical appearance or possible disfigurement which would affect his family relationships or his work as a salesman?

As a result of this discussion with the physician, plans for surgery were delayed, and all personnel in contact with Carter were alerted to observe his behavior. They were trying to help the patient express his feelings about the projected surgery, to alter the care plan in terms of these feelings and to foster Carter's active participation in the plan.

It was a vigilant graduate nurse who noticed a rosary in the drawer of Carter's bedside table. She informed the visiting priest who on his next visit did not discuss religion but engaged in cheerful conversation throughout the ward. Carter joined in and later told the nurse that the priest was "a regular fellow" whom he'd like to see again.

Following a second conference of the doctor, nurses and social worker, the priest was called in and briefed on Carter's background. A personal interview was arranged.

When the doctor arrived a few hours later, the patient for the first time asked directly about the surgery. The doctor discussed in detail the possibility of the tumor's being malignant or benign and the surgery that would result from either diagnosis. Carter said he had not realized that doctors discussed such matters with patients and that he preferred to face facts. In the end, the scheduling of the operation represented a joint decision of the physician and the patient.

Harold Carter was lucky to find himself in a hospital where the nursing personnel who are in most frequent contact with patients planned with doctors for the patient's physical and emotional needs. Furthermore, by assisting the graduate nurses, the practical nurses and volunteers did their bit to leave highly trained professionals free for more scientific duties. Because about 65,000 graduate nurses are needed but unavailable to civilian hospitals, more than 50 per cent of the nursing care administered in this country is done by non-professionals.

Since 1950, in a revolutionary move to help improve hospital care, nursing leaders from Columbia University's Teachers College have been evolving a new philosophy of "team" nursing. A pilot experiment—in which a team of professional and non-professional nurses work together as a unit in planning, giving and evaluating care of the patient—has been carried out in New York City's Francis Delafield Hospital and has been partially subsidized by the W. K. Kellogg Foundation. From here the team nursing idea has spread to many hospitals throughout the country.

In the initial project, nursing care has been administered by teams headed by a graduate nurse and including a practical nurse, orderly and hospital attendant. While in many hospitals the increasing use of non-professional personnel has resulted in poorer care, the new approach leads to better nursing, better job satisfaction for the team of personnel, and smoother organization.

The 90 million Americans who hold some form of hospital insurance and the 250,000 who use some type of nursing service every day may soon derive the benefits of team nursing and more complete nursing care.

How does team nursing work?

When a patient is admitted to a hospital, his nursing plan is developed by all those who will participate in his care. The program may be revised at daily team conferences. Team members work out assignments jointly, but under the guidance of the head nurse, the team leader bears the responsibility for decisions. As the physician delegates responsibility to her, she may delegate part of it to members of her team, and sometimes even to the patient or his family. The team leader is, like the physician, a practitioner participating directly in patient care. Both are administrators secondarily only.

The practical nurse, under the supervision of the professional nurse, can assist in routine care if the patient is partially able to help himself. Nurse's aides also help him to care for himself. Their skills, readily learned on the job, include hygienic and homemaking abilities. For example, a nurse's aide may help a patient with his bath, if only by providing towels, wash cloth and soap.

But the eyes and ears of the non-professionals are as important as their hands. Their careful observation can contribute much to the team's over-all evaluation of the patient's response and nursing needs. At conferences they discuss with their professional team-mates his reaction to hospitalization and illness. To help plan his care the team needs to know how he has adjusted to a roomful of strangers. Nursing personnel look for signs, meaningful perhaps only when placed together in the total picture. Was he out of bed? Was he sitting in a chair? Walking around? Did he talk to anyone? If he did not, what was

Members of the nursing team gather for their conference. This six-member panel is a fuller complement of participating personnel than is available in many hospitals. One nurse illustrates a point of patient-behavior rather graphically.

The team leader supervises the members of her unit as they perform their assigned duties. The practical nurse helps to care for a patient requiring intravenous therapy, while the nurse's aide assists a more fortunate patient out of the bed.

he doing? Did he talk to hospital personnel? When one of them said something to him, how did he react? What did he answer? Did he ask questions about his illness, the doctors, nurses, etc? What were his exact words? How did he say this? Did he smile or frown?

The patient needn't fear, though, that untrained personnel will interpret the signs and symptoms of his illness. Nurse's aides describe rather than interpret facial or postural expressions, general activity and deviations from normal reactions, such as vomiting, diarrhea, bleeding and difficulty in breathing. Interpretation is left to professionals.

Tasks are divided so as to leave scarce, highly-trained nurses free to use their extensive scientific knowledge. Consider bed baths as an example.

Miss Green, an orthopedic patient, is prepared for surgery by a graduate nurse who also cares for her immediate postoperative needs, both physical and emotional. Her bed bath, at first requiring the graduate nurse's skill in directing patient movement, may be turned over several days later to a practical nurse.

Elderly Mr. Crawford, on the other hand, enters the hospital for uncomplicated surgery. On the day following the operation the practical nurse may help him with his bed bath.

Mrs. Moran, almost ready for discharge, requires the attention of only a nurse's aide for her bed bath because she can attend to everything but washing her back.

Care of patients with leg fractures may offer another example of division of labor within the nursing team. Young Billy McGee, who slid too hard into second base, enters the hospital with a fractured ankle. Before application of his cast, when any movement may cause further damage, a graduate nurse cares for him. Once the cast is on and bone movement stabilized, certain phases of his care may be turned over to a practical nurse. She is fully qualified to watch for a change in the color of his free toes or for other signs of numbness. When Billy is ready to learn crutch-walking, the graduate nurse is his teacher. But crutch-walking mastered, Billy may be assisted by the practical nurse or later even by a nurse's aide.

The team method of assigning nurses offers a chance for more complete patient-care than the popular "functional" method. Functional nursing apportions tasks for economy of time and expediency of service with one person assuming responsibility for a group of similar jobs. For example, one person may administer all medication. Another may take all temperatures. In this "assembly line" approach nurses frequently become so concerned with routine treatments and medication that they lose intimate contact with patients.

Under the "case" method total nursing care is assigned to one member of the nursing staff. This often worked well enough when graduate nurses were plentiful, but is impossible today unless patients can find and afford a private duty graduate nurse.

Under team nursing, each unit contains members chosen for their ability to provide the best care for each patient. It may consist of any combination of members of the nursing staff, depending on number and training of personnel available, type of hospital, state regulations, and most of all the patient's needs.

Proponents of team nursing do not view it as a cure-all for the nursing shortage or as a panacea for other problems of the nursing service department. But in the words of Eleanor Lambertsen, director of Columbia University's team-nursing studies: "It recognizes the changing role of the professional nurse in relation to the increasing numbers of non-professional personnel. It is an attempt to meet the increased demands for nursing service and is based on the philosophy that the individual patient is the deciding factor, and that all personnel having contact with the patient and his family share in and can contribute to the planning, providing and evaluating of nursing care."

Corneal Transplantation

by Harry Ernsting, M.D., and Mary Ernsting, R.N.

FOR MORE than one hundred years doctors have struggled with the problems of corneal transplantation. At first these problems defied solution and the operation was in most instances a miserable failure. As understanding increased, failures became less frequent until finally corneal transplantation became an accepted surgical procedure.

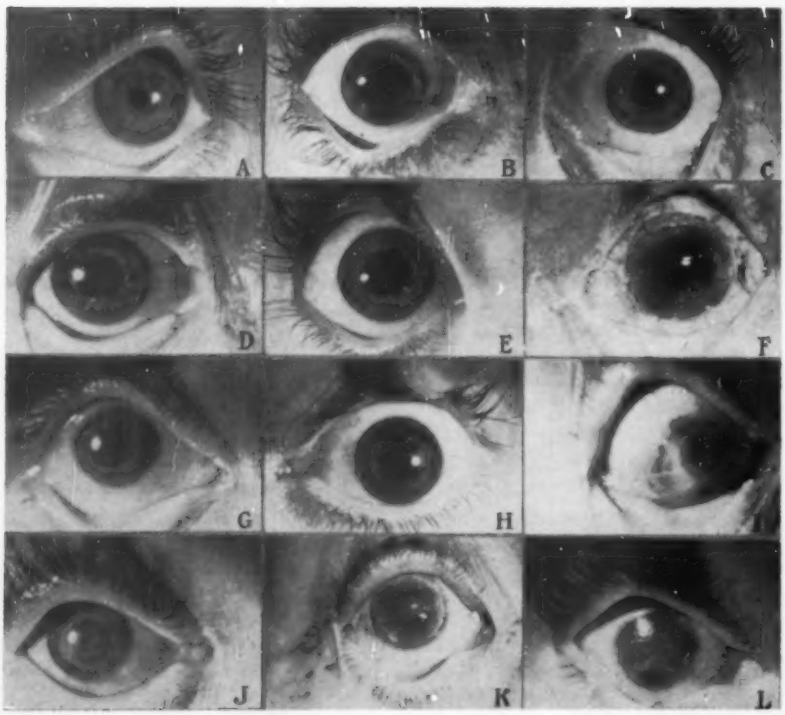
The normal cornea is thinnest at its center and greater in its horizontal than in its vertical diameter, but for practical purposes, it is considered to average 1 mm. in thickness and 12 mm. in diameter. For many years this tiny tissue resisted successful transplantation, but during these discouraging years many valuable things were learned. Paton[1] has reviewed corneal transplatation historically.

It was learned that grafts obtained from the same individual (autotransplants) or from the same species (homotransplants) could be used successfully, while heterologous transplants (different species) always failed. Autotransplants are seldom, if ever, used anymore. Homotransplants are the choice today. Suitable grafts, it was learned, could be obtained from stillborn babies or octogenarians but had to be free of any disease process. In this regard, Castroviejo[2] has recommended that grafts intended for use in the treatment of keratoconus should be obtained from adult donors because of better resiliency. In many cases it was found possible to obtain more than one graft from a single donor cornea.

Grafts may be total or partial penetrating, or total or partial lamellar. Total penetrating grafts include the entire cornea. Partial penetrating include a small disc (usually 4.5 to 7 mm. in diameter) of the full depth of the cornea. Total lamellar include the entire external half (or as near to Descemet's membrane as possible) of the cornea. Partial lamellar include a disc of cornea usually about 5 to 7 mm. in diameter and 0.5 mm. in depth. These will be discussed in greater detail.

Keratoplasty or corneal transplantation is not a panacea for all forms of corneal damage or blindness. It has very definite indications and contraindications even though each case usually presents its own problems and demands its own special solutions. In brief, however, the procedure is contraindicated in cases having as much as 20/200 vision or in cases showing active infection, inflammation, or abnormal elevation of tension. Inflammation, whether it be due to mechanical, bacteriological, chemical or other cause, contraindicates operation until it has subsided and remained quiescent for at least six months.

Keratoplasty is indicated in many conditions. In relation to results, Castroviejo[3] divides them into three main groups. Briefly, most favorable results have been reported in kerataconus, in central opacities that are surrounded by healthy cornea, and in cases of inactive interstitial keratitis with slight nonextensive opacities where the graft will remain in contact with good corneal tissue. Less favorable results have been reported in descemetoceles, interstitial keratitis with somewhat denser and more extensive opacities, some extensive superficial opacities, some adherent leucomas, some superficial chemical injuries, and Fleischer's, Haab-Dimmer's, Groenow's, and Salzmann's types of dystrophies. Unfavorable results have been reported in nystagmus, amblyopias, aphakia, deep destructive chemical burns (like lime burns), extensive scars that include the pupillary area and ex-



Eyes that have already been subjected to partial or total lamellar keratoplasty. A to J—partial keratoplasty; K and L—total keratoplasty. (Castroviejo)

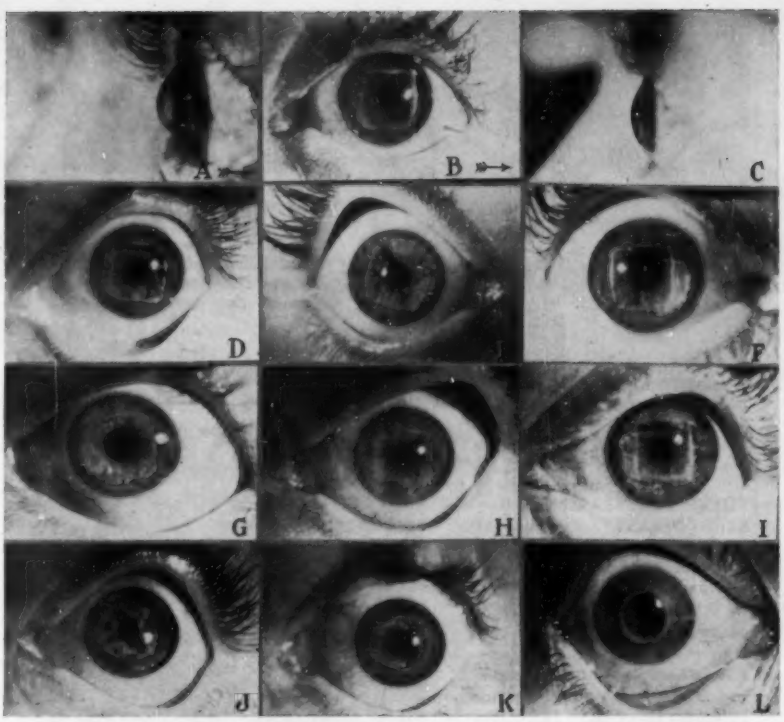
tend to the limbus, band-shaped opacity, extensive leucomas, extensive opacities with pannus or heavy vascularization, Fuch's dystrophy, and fatty degeneration.

Lamellar keratoplasty[4] gives less visual improvement than the penetrating, but it is far safer. It is therefore to be preferred in aphakia,[5] one-eyed individuals, children, unruly patients, for cosmetic purposes, superficial opacities (especially those with good surrounding cornea), and in preparation for penetrating grafts, with or without preceding beta radiation.[6] In cases where keratectomy[4] will serve as well as lamellar keratoplasty, it should be preferred. Therapeutically, Paufique[7] recommends lamellar keratoplasty for all progressive forms of chronic or recurrent keratitis when ordinary therapy fails, when the corneal center is endangered, or when corneal perforation threatens. It has been found of value in the treatment of complicated or far-advanced cases of herpetic ulcers, superficial punctate keratitis, recurrent erosions, recalcitrant ulcers, in some cases of Mooren's ulcer and bullous keratitis, and in place of delineating keratotomy.

Total penetrating keratoplasty has always been considered unsuccessful. Recently, however, Castroviejo[8] offered a preliminary report regarding its use to indicate the possibility of improving eyes for which surgery was heretofore considered impractical.

Having found that keratoplasty is indicated, that a certain type must be used, and that no obvious deterrent factors exist, the patient is hospitalized and physical and laboratory examinations, including conjunctival smears, are made. The nose, throat, and sinuses should be checked. Any factors that are likely to influence the results adversely such as foci of infection, systemic disturbances, etc., should be corrected. When no contraindications to the operation are found, or when conditions are most favorable, the patient is scheduled for surgery.

The preoperative care is similar to that used in cataract extraction, but varies with the case at hand and at the discretion of the surgeon. If necessary measures are taken to improve the patient's general condition. Barbiturates are given on the evening before surgery and again one hour prior to surgery. An enema is given on the evening before and usually repeated early on the morning of surgery. Of course, where general anesthesia is to be used, the morning barbiturates and local anesthetics are omitted and, usually, morphine and atropine sulfate are administered hypodermically. No breakfast is permitted on the morning of surgery. Some surgeons



Partial penetrating keratoplasty: A—keratoconus before operation; B and C—after operation: D to I—square transplants, J to L—circular transplants. (Castroviejo)

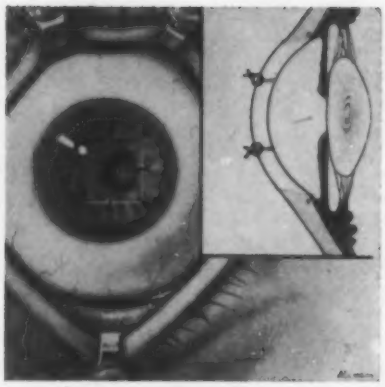
contract the pupil with a 2 per cent solution of pilocarpine. Others dilate the pupil with a 3 per cent solution of atropine. Still others combine the principles of both by contracting the pupil before surgery and dilating the pupil immediately after the operation. This remains a disputable issue. Drops of 1:2500 acqueous Metaphen® solution are instilled the evening before and again about thirty minutes prior to surgery.

Immediately before surgery, the area around the eye to be operated is cleansed and prepared in the usual manner, and the patient is draped. The conjunctival sac is irrigated with Ringer's® solution and 2 drops of 1:2500 aqueous Metaphen solution are instilled. Local anesthesia is performed by the instillation of two drops of ½ per cent Pontocaine® solution at intervals, by subconjunctival injections of a few drops of 2 per cent procaine and 1:1000 epinephrine solution to deepen anesthesia, and by the injection of 2 per cent procaine solution at the temporal area of the lids, after the manner of Van Lint,[9] to produce lid paralysis and prevent lid squeezing. In grafts larger than 7 mm., a retrobulbar injection of 1 cc. of 2 per cent procaine solution is also necessary. Superior rectus sutures are rarely needed. Lid sutures or mosquito lid-clamp retractors are used to control the lids.

The shape of the graft may be square[10] or round. The former is made with a double-bladed knife, the blades of which may be regulated. Because of their greater useful area, square grafts are reported to be especially suited to the treatment of keratoconus.[2] Round grafts are made with a trephine, which may or may not have a depth guard. Stansbury[11] concludes that a round graft is easier to make and that the results with it are better. Many agree that the round graft is easier to perform, but feel that in the proper hands the square graft gives equally good results. By means of Castroviejo's trephine with micrometric regulation, the depth of the cut can be regulated from 1/20 mm. to several mm. It is made in sizes 4 to 12 mm. Sizes up to 9 or 10 mm. are used for the partial graft, while those from 10 to 12 mm. are used for total lamellar grafts. For most purposes, a 6 to 7 mm. size is used. The same size trephine is used to cut both the plug from the donor and the hole in the recipient cornea.[12]

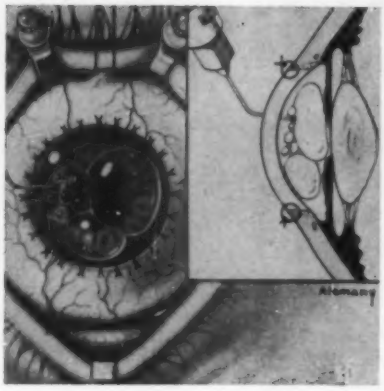
Each form of keratoplasty is performed after a pattern peculiar to its type. When complications are met, the technic is extended and varied to deal with them. Herein, only the technic of performing uncomplicated operation is presented.

In the performance of partial penetrating keratoplasty a cut is made, with the trephine, through the superficial layers of the cornea to outline the site



PARTIAL PENETRATING KERATOPLASTY (Castroviejo)

Dissection of the leucomatous area is made with the double-blade knife for the square graft or with the trephine for the circular one. The graft is dissected with similar instruments and sutured edge-to-edge in the recipient cornea.



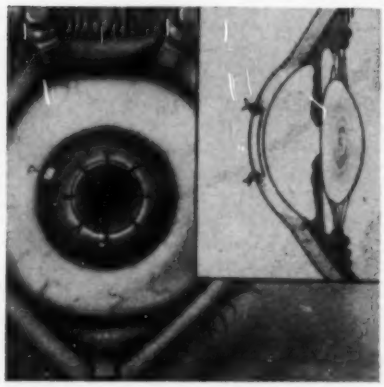
TOTAL PENETRATING KERATOPLASTY (Castroviejo)

The leucoma is outlined by the micrometric trephine to a depth of 0.5 mm. and to a size to accommodate the leucomatous area to be removed. Occasionally, where the anterior chamber is abnormal, the operation is more extensive.

of the intended transplantation. To accentuate this outline, one drop of 2 per cent colution of sodium fluorescein is instilled and immediately washed out with Ringer's solution. This stains the outline a brilliant green and makes it easy to see. A suture is inserted into the outlined leucomatous area to serve as a handle to aid in its future removal. Then 6-0 sutures are fixed 1 mm. beyond this outline in the recipient cornea to form rectangles, triangles, or other holding designs over the transplant site. These sutures are left loose until the scarred plug has been cut and removed and the clear donor graft has been inserted in its place. Then, they are properly tensed and tied. Instead of overlying sutures, border-to-border sutures may be used, and sometimes they are used in combination with overlying sutures. Care in suturing is essential to avoid perforation of the anterior chamber.

The cut that was outlined on the recipient cornea is then extended, with the trephine, through the cornea until it penetrates the anterior chamber, at which time the cutting is completed with the curved corneal scissors and the plug is removed. The donor graft is fitted into the resulting hole in the recipient cornea and the preplaced sutures are tensed and tied. Two drops of a sterile 3 per cent atropine solution and 1:2500 aqueous Metaphen solution are instilled, and both eyes are padded.

In total penetrating keratoplasty, according to Castroviejo,[8] the leucoma is outlined by the micrometric trephine set to a depth of 0.5 mm. and to a size to accommodate the leucomatous area to be removed. After entering the anterior chamber with a knife, the incision is completed with a keratoplasty scissors. The leucoma is removed and replaced by a donor graft that is sutured border-to-border with 6-0 silk in a Grieshaber needle. Air is then injected into the anterior chamber in an attempt to prevent the formation of adhesions. In cases with an abnormal anterior chamber, lens, etc., the operation is more extensive since it will necessarily include work upon them.



PARTIAL LAMELLAR KERATOPLASTY (Castroviejo)

Dissection of the leucomatous area is made with knife or blunt scissors so as to remove a disc of even thickness. The donor graft is secured in a similar manner and is placed and sutured edge-to-edge in the recipient cornea.

In the performance of lamellar keratoplasty the trephine is usually set to cut no deeper than 0.5 mm. In partial lamellar keratoplasty the leucomatous area to be exercised is cut, and a suture is placed at its edge to aid in starting the dissection with a knife. This is completed with the knife or with blunt scissors in such a manner as to secure removal of a disc of even thickness. The graft is obtained from the donor eye in a similar manner and is placed and sutured edge-to-edge in the recipient cornea. Total lamellar keratoplasty is performed in almost the same manner as partial keratoplasty. The only difference is in the size of the graft.

Postoperatively, the patient is placed supine and is kept as quiet as possible. A pillow is allowed; the head of the bed may be elevated slightly, and a break is permitted in the region of the knees to add to his comfort. Some patients can be turned on their unoperated side within the first twenty-four hours. Psychotic states, pain, and other unusual symptoms require an immediate report to the surgeon. Special permission and orders should be obtained for any necessary catherization. No laxatives or enemas should be given without special written orders. A liquid diet is given the first day or so. Thereafter, the diet is graded to semi-liquid and then regular as indicated. Care must be used in feeding to avoid coughing, choking, or any strenuous effort. The first dressing is usually done two days after the operation, 2 per cent atropine solution and 1:2500 aqueous Metaphen solution are instilled, and the eyes are re-covered. Instead of aqueous Metaphen solution, other appropriate antiseptics or antibiotics may be used. Every second day thereafter the eye is redressed in this manner. Between the seventh and fourteenth day, the sutures are removed under local or general anesthesia. Between the fourth and the seventh day, Cascara is given; it is followed the next morning by an oil enema. On the tenth day, the unop-

erated eye is uncovered and the patient is allowed to get up. In some cases, this is possible by the fourth day. On the fourteenth day, the operated eye is uncovered. When all signs of inflammation have disappeared, atropine is stopped. In keratoconus, Castroviejo[2] recommends bed rest with liquid and semi-liquid diet for about seven days, during which time the eye should not be examined. In these cases, he also suggests the use of pressure dressings from the fifteenth to about the thirty-fifth day in order to obtain a more normal corneal curvature. Others find pressure dressings unnecessary.

To lessen the risk of using potentially contaminated and often inadequately stocked floor trays, a special dressing tray can be made up for the patient's sole use, and may be kept in his room. The following sterile supplies should be included, routinely:

1. Small jars containing boric acid sponges, 2x2 dry gauze sponges, eyepads, a sterile container for dressing forceps, and sterile towels.
2. A small emesis basin, bandage scissors, and a roll of one-half inch adhesive or Scotch tape.
3. Dram dropper bottles containing 2 per cent solution of atropine, 2 per cent solution of pilocarpine, 1:2500 solution of aqueous Metaphane, Ringer's solution, and ½ per cent solution of Pontocaine.

To this basic list, instruments and other sterile supplies and medications may be added as ordered, or as the need arises.

Complications[12] can and do occur in keratoplasty. Perforations of the anterior chamber, either during insertion or removal of sutures, is vexing but rarely serious. Postponement of operation or conservative treatment suffices for its management. Minor abrasions heal rapidly. Lens injuries may be very serious. In a young child, the soft lens may absorb without bothering the graft, but in the older groups, all or as much of the lens as possible should be removed at the time of injury. Anterior synechia is a frequent complication and, if very small, may sometimes be freed by miotics or mydriatics. If more extensive, surgery must be done between the fourteenth and twenty-first postoperative days. If done earlier, the graft might be dislodged; if later, the graft might have had time to become opaque. Infections, such as uveitis, are treated in the usual manner. Secondary glaucoma often causes complications. Some cases respond to medical treatment and miotics; others require appropriate surgery.

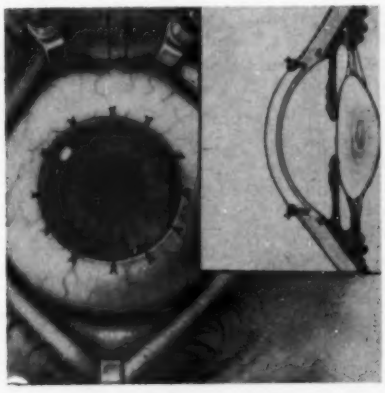
Postoperative vascularization may be treated by radiation. Allergy is reported to play a sinister role in ocular complications. Castroviejo[13] believes that this allergy is often of bacterial origin and that the foci of infection frequently lie in the paranasal sinuses. Maumenee,[14] however, believes that the allergy is a result of donor-recipient sensitivity. Treatment consists of the use of foreign protein, antibiotics, cortisone,[15] antihistamines, etc., to control the allergy while the cause is sought and eradicated, if possible. Dislocation of the transplant, if small, may often be treated conservatively, but a large dislocation requires immediate surgery.

What happens to the patients whose grafts become permanently cloudy and opaque? It is possible that some may benefit by retransplantation. Castroviejo[16] has presented cases where, after one or two retransplant failures, he was finally able to obtain clear grafts and definite visual improvement. Some cases may require preparation by preliminary radiation, surgery, etc., before the keratoplasty is attempted. In cases where the grafts have become permanently cloudy, repeated keratoplasties may be favorably considered so long as the surrounding recipient cornea remains capable of preserving transparency. At least six months should elapse between operations.

What happens to the graft that "takes"? Katzin[17] has reviewed the ultifate fate of the graft. It seems that the cellular elements of the host gradually fill in the matrix framework of the donor graft and the defects in Bowman's membrane. Descemet's membrane can regenerate itself. The nerve[18] supply is replaced by nerves grown from the host around the graft.

Corneal transplantation has come a long way since its inception, but the results, as might be expected, are still not perfect. A great deal has been accomplished in the recent past and under the stimulation of increasing interest even more may be expected in the future.

Illustrations have been reprinted through the courtesy of Ramon Castroviejo, M.D.



TOTAL LAMELLAR KERATOPLASTY (Castroviejo)

The technique is practically the same as in partial lamellar keratoplasty. The only difference is in the thickness of the graft. In the performance of lamellar keratoplasty the trephine is usually set to cut no deeper than 0.5 mm.

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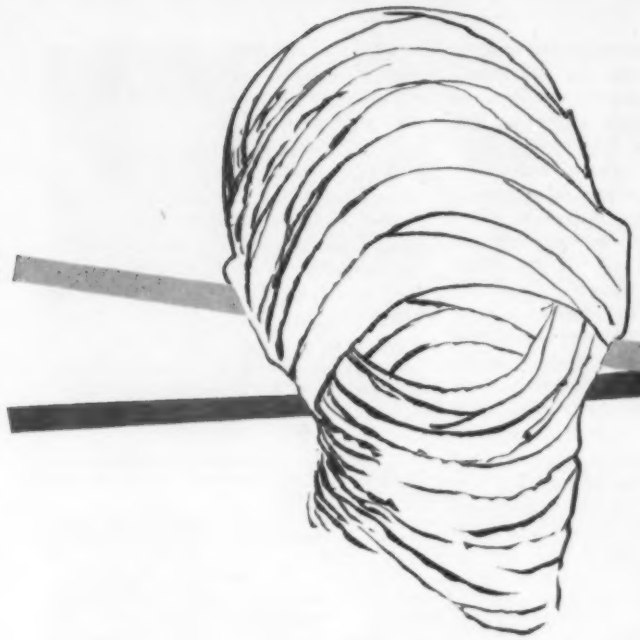

Nursing

Physiologic and Psychologic Trauma is Faced Courageously and Sympathetically by the Practical Nurse.

by Ruth Boyer Scott, R.N.

EVERYONE IN town knew about the cream-colored convertible. Young Mr. Cabot had received the car as a wedding present from his father, and the young couple drove away in it on their honeymoon trip.

Two months after their return, the registrar of General Hospital telephoned Miss Warren. "Will you please come at once to the hospital?" the registrar asked. "It's an accident case — young Mrs. Cabot, you know." Miss Warren," a practical nurse, did know; everyone in town knew the Cabot Mills and the Cabot family. "Their convertible smashed into a cement separation. He was thrown clear, but she hit the windshield."

Miss Warren arrived during the emergency room procedures. Mrs. Cabot's beautiful face was completely covered with pressure bandages, slightly blood-stained. One fractured arm had already been set; the surgeon was setting the other arm.

The family doctor was taking charge of the patient's general condition. A blood transfusion had already been started to combat general shock and the loss of blood.

He turned to Miss Warren, "I'll need penicillin and tetanus toxoid. Please take these slips to the pharmacy for emergency issue."

At the pharmacy Miss Warren checked the medications against the doctor's orders, and signed the pharmacy book. Back in the emergency room, the medications were re-checked by the doctor and the professional nurse.

Then Miss Warren prepared two separate hypodermics. The ordered dosage of penicillin was to be given in a deep muscular area, preferably the upper outer quadrant of the buttocks. With the assistance of the family doctor, Mrs. Cabot's hips were rotated carefully so as not to disturb the transfusion needle or the fracture-setting. The penicillin was injected and the patient's hips allowed to roll slowly back to the supine position.

"I want to explain why I ordered tetanus toxoid instead of tetanus antitoxin," the doctor told the nurses. "I've cared for Mrs. Cabot since she was a baby. I personally know that she had DPT (diphtheria-pertussis-tetanus) immunization because I gave it to her. She had a booster of diptheria toxoid before her last trip to Europe. Because she has had this long-time immunization which toxoid gives, it is safe today to give her a tetanus toxoid booster. Toxoid rarely causes any reaction. When it does, the reaction shows within ten minutes and is controlled by adrenalin.

"Ordinarily, in a serious accident like this, with dirty wounds, incurred in the country near a dairy farm, I would surely give tetanus antitoxin. Antitoxin carries a 10 per cent risk of severe serum reaction. Mrs. Cabot avoids this risk because of her earlier toxoid immunization."

Miss Warren injected the tetanus toxoid, as directed, subcutaneously in the deltoid area of the left arm.

"Now, Miss Warren, if you'll prepare a shock bed for Mrs. Cabot," the doctor continued, "we'll be ready with our part of the treatment when the surgeon completes his work."

The shock bed was prepared in the recovery room near the surgery. Three covered hot-water bottles were inserted to warm the bed. Covers were loosened at the foot of the bed and folded upward. The side of the bed was prepared for quick fanfolding when the patient arrived. However, to keep the bed warm, the covers were left in place over the top of the bed.

Testing the bed, Miss Warren assured herself that she knew which way to turn handles in order to lower the head of the bed after the patient was transferred.

When Mrs. Cabot was brought to the room, Miss Warren quickly removed the hot water bottles and fanfolded the covers to one side. Because the patient was unconscious, with two fractures, and a transfusion in progress, three persons lifted her while Miss Warren held the transfusion bottle.

For two hours Miss Warren recorded the patient's pulse and respiration at ten-minute intervals. The professional nurse recorded the blood pressure every half hour. The rapid weak pulse, characteristic of shock, gradually slowed and strengthened.

To avoid another needle injection, the emptying blood transfusion was replaced by a glucose saline solution as ordered by the doctor.

The Disfigured Patient

As Mrs. Cabot began to moan and stir, the professional nurse asked Miss Warren to give the first injection of the p.r.n. sedative ordered by the doctor. In General Hospital, the decision as to when to give a p.r.n. (if occasion arises) medicine must be made by the professional nurse, although the practical nurse may suggest the need from her observation of the patient.

After Mrs. Cabot recovered from the danger of acute shock, Miss Warren found her duties undramatic until a week had passed. At the end of a week the dressings covering Mrs. Cabot's face were removed by the doctor. Doctor and nurses tried not to display emotion as they gazed at the changed bride. Her face was swollen and gouged on the left side, and the left eyelid was distorted.

The doctor calmly reached for a sterile dressing, but Mrs. Cabot stopped him with a piteous cry, "Let me see."

"I'd rather you would wait for a month, to let healing continue," he advised.

"I have to see *now*." Mrs. Cabot insisted.

The doctor nodded to Miss Warren to bring a mirror. He casually removed an emergency sedative hypodermic, of the disposable type, from his inner suit pocket. Even as Miss Warren handed the mirror to the once-beautiful Mrs. Cabot, the doctor was injecting the medicine.

Through the sobs of the stricken young woman, he explained that time and plastic surgery would restore her face.

When Mrs. Cabot left the hospital she took Miss Warren with her. The nursing chores were simple. Since the patient had both arms in a cast, Miss Warren fed her, bathed her, and helped her with dressing and bathroom necessities. The psychological aspect of her duties was the real challenge. Mrs. Cabot had hours of depression when she was sure her husband couldn't love her and was being kind out of pity. Miss Warren practiced two fundamental skills—listening and reassurance. She was the only person to whom Mrs. Cabot unburdened her anxieties.

When the plastic surgeon decided Mrs. Cabot was ready for surgery, Miss Warren accompanied her to the hospital. She gave the ordered sedation and atropine. "Your mouth will be dry in a few minutes," she explained. "This makes it safer for the doctor to care for you."

Since plastic surgery requires extensive surgery, she urged the anxious relatives to stroll outside. When two hours had passed, Miss Warren slipped quietly into the corridor of the surgery and observed the seemingly uneventful progress of the operation through the window. She passed on this reassuring news to the family. Mrs. Cabot spent four hours on the operating table, and during this time the morale of the relatives was maintained by Miss Warren.

When the patient was returned to her room, awake and in good condition, with her face freshly bandaged, she was greeted by her husband and parents. Miss Warren suggested that they say "good-bye" and come back in several hours. Their departure was well-timed for Mrs. Cabot immediately developed a distressing bout of vomiting. Miss Warren gave her bits of cracked ice to suck until her stomach had settled.

This period of hospitalization lasted only six days. During this time Mrs. Cabot was ambulatory. Penicillin was given routinely. The patient took only soft foods so that chewing would not distort the stitches. Again Mrs. Cabot was alternating between hope and despair, and Miss Warren's chief duty was to support morale. The trust already established between patient and nurse was of great help.

On the tenth day Mrs. Cabot was to have her stitches removed. Miss Warren told her she had seen stitches removed on many occasions and knew this to be a painless procedure. While Mrs. Cabot lay on the table in the plastic surgeon's office, Miss Warren maintained a cheerful expression so as not to arouse apprehension. The area of the operation showed thin red lines, but the distortion and the gouging were completely gone.

Mrs. Cabot was allowed a mirror, and the doctor explained in detail about the lines. She was told they would become white and almost inconspicuous in time. From a weird distorted face she had regained a lovely one. More important, Miss Warren recognized, the patient had regained confidence in her social acceptability.

Let's Talk It Over

by Theresa G. Muller, R.N.
Nursing Director, Indiana Division of Mental Health, and
Assistant Professor of Psychiatric Nursing, Indiana University

IN a study of the emotional factors which affect all nursing care the nurse's ability to achieve insight into these emotions must be considered. Thus a patient who displays anxiety, fear, resentment, or other negative reactions to an illness is not readily helped by the nurse with similar unresolved difficulties of her own. In this connection we might explore somewhat the universally experienced emotion of fear.

Fear may be manifested in various degrees and is characterized by alarm, disquiet, awe, dread, and, when unreasonable and intense, by "phobia." It is a reaction to a conscious realization of danger and is usually distinguished from anxiety which is founded on unresolved, repressed conflicts. (See November 1953 issue of *Nursing World*.)

Fear originates with some new situation which can not be readily understood or mastered. A baby is frightened by a loud noise, a sudden movement, or a sense of loss of support. As earlier fears are outgrown, new ones are acquired of things apprehended but not understood. Fears, then, arise in unfamiliar or new experiences which seem so overwhelming that one is unable to cope with them. Some fears generated in childhood persist throughout life—fear of losing love, of being deserted, or of being mutilated. A fear of failure may in later life be transferred to other objects and things. For instance, fear of rejection may bring about fear of expressing love or hate, approval or disapproval. A repressed fear generates dynamisms which are expressed in irrational behavior, somatic symptoms, or personality disturbances with or without anxiety.

Fear of actual danger causes a person to react with flight or fight according to the estimated degree of the danger and the relative strength to cope with it. A threat to the self may arouse a protective counteraction, a withdrawal from similar situations. Rationalization through self-vindication then denies the pain of the feared humiliation and ridicule. Fear contributes to the sentiments of awe and reverence, to caution and vigilance. It may show itself as timidity and worry.

Fear is a normal reaction to physical and psychological hazards and arouses physiological aspects of preparedness to combat them. Self-protective caution is necessary to existence and is harmful only insofar as its intensity and duration remain unneutralized. Fear of moral dangers has a deterrent effect and thus society is protected from destructive influences except in those instances where fear is an attracting rather than a repelling force; antisocial behavior or unconscious guilt feelings which seek punishment then become evident. On the other hand, fear of isolation or of losing contact with others can be a deterrent factor in tendencies to antisocial behavior. Fear of a common danger is frequently a unifying factor which leads to constructive action as when fear of communicable disease arouses concerted efforts toward public health control.

Fears are normally outgrown as assurance is gained through mastering the situation that caused them. Development into a mature, self-reliant person is characterized by the ability to meet unfamiliar and disturbing slights to self-esteem without being overwhelmed. Fear is neutralized through group activity organized to overcome a common grievance. It is associated with other negative reactions such as hostility, jealousy, greed, and power and may be expressed overtly or repressed to operate in devious ways.

The deterrent effect of fear on the individual relates to other personality phases. It may limit the destroying effects of anger, so that indecision, confusion and other manifestations of conflict result from the strong clash of opposing tendencies.

There are variations in the basic character of everyone which affect his capacity to react to fear. Security and self-confidence in early childhood tend to lay the foundation for our ability to cope effectively with physical or psychological dangers. Fears become abnormal when they are maintained beyond the situation which caused them. The original stimulus may be projected to an outside source or there might be an unreasonable reaction as in a phobia. Worry may be shown about vague matters or specific aspects in everyday life. One person may be unduly concerned about his own physical ailments while another may be concerned about the welfare of someone who in one way or another is a necessity or a threat to his security.

These, then, are a few abstractions about fear. Let us see how they are related to the real life situation of a graduate nurse whose work involved teaching basic nursing students.

"Faced with the necessity to write a term paper on the application of the theories on the foundations of human behavior to my own personal and professional experiences, I began to think about the emotion of fear as it could be observed in our class and as it has been experienced by myself. Why, for instance, is it so difficult for anyone of us to present a report before the class

group? Why are we so fearful of our ability to be accepted by the group? Why does anyone of us feel that any variance to the approaches of the others is threatening or disadvantageous? Why do I resist the use of the discussion methods in this class and find their use difficult in the teaching of my own classes? Why do I continue to use these methods when the results seem so unsuccessful?

Purpose of the Course

"Now in considering the purposes of this course, I am faced with this question: In trying to evaluate the dynamics of the human behavior of others, am I fearful of exploring deeply into my own reactions? Why do I dread an aggressive student in my class? Do I really mean what I say about students not needing to agree with me? Am I afraid of being unable to control the situation unless they do?

"I now recall a few previous estimates about myself based on some helpful guidance which gave me a basis for self-evaluation toward better self-acceptance. Why, then, do I continue to be so defensive about maintaining my opinions and still fearful about taking on leadership responsibilities? A look into the past at this time might help better to understand the present with what might be constructively possible in the future.

"As a child-product of a broken home I had been shifted from one home situation to another and soon learned to be very adaptable. My feelings could be hidden from view or shown at will to get what I wanted. Co-operation could be offered or not as it suited my advantage. Lying seemed more satisfying than truth-telling. During high school days I was considered a very retiring person—good natured, but shy, more a spectator than a participant in the social activities of my class-mates—the good girl who could always be depended upon to carry out responsible activities. My fellow-students tried to include me more actively but I was so ill-at-ease that this was not possible, and the pattern continued through college and student nursing days.

"As a graduate nurse, I tended to get myself into situations under some dominant, authoritarian person. Nevertheless any power over me was deeply resented. I wanted to feel dependent and yet be free and have my own way. Discord or friction was unbearable. To please and to ingratiate myself with others seemed most necessary especially when there was any indication of falling from favor with those in authority. I recall the conflicts engendered in my childhood about any decision which had to be made relative to the time to be spent with the different members of the broken home. A relative or friend usually was ready to give some security to me as an unhappy child whose suspicion of friendly gestures had to be relieved. Later, teachers continued to play the same role by letting me stay after school or tag along on errands with them.

"As can be seen, my behavior could scarcely be considered consistent nor my response very integrated. My good qualities and outstanding abilities were approved by some and my chameleon-like nature reflected laziness, stupidity and untrustworthiness according to others. I did not know myself as an individual and therefore could scarcely be assessed as myself by others. I lacked self-respect and self-confidence.

"So, it seems as though the basis for my fears are well-founded. No home, family, or money left me cheated of many things generally accepted by others as a matter of course. Some persons made me fearful, took away my independence or the right to make mistakes without the fear of undue punishment. Serious and worried most of the time, I was afraid of storms, of the dark, of fire. Taking any chance was too great a threat even though I secretly dreamed of being a heroine in daring exploits. Even the thrilling rides in the amusement park held terrors for me and electric stairways were always avoided. Games were secretly coveted but were easier to avoid than to compete for excellence in them. I was bitter with my parents for not buying me skates, for not teaching me how to swim, for not making a home where I could receive my friends. It was a revelation to me when I found a friend with sufficient patience to help me work through some of my fears. She gave me a feeling of security by indicating that compliance was unnecessary to maintain a friendship, that acceptance did not rest on agreement or approval alone. By expecting myself to be perfect to please others I was using the same standard for the expectation of what they should be. By lacking in self-respect and self-regard others were kept at a distance. I learned to get some kind of approval from superiors by following instructions, doing my work well, and by being agreeable.

"Rebellion was courted but the courage was lacking. True, aggression is basic to existence but I was afraid that the power to control, to modify, and to direct it might be lacking and that it would get out of bounds and destroy. Rapport was readily established with students who came for help. Somewhat different was the classroom situation where I was unsure and ill-at-ease.

"With all these concerns of my own, I viewed the movies for this class and lived each one with my own emotions which gave singular meaning to the text book descriptions of them. The little boy in *The Preface to a Life* reflected fear, anger, and resentment and the need to be loved. I was helped to see that similar needs of my own were seeking satisfaction from co-workers and others. The girl in *Hostility* clarified the way in which successful achievements may help one to sublimate the real needs so that an appearance of success is evident even though there is an impaired capacity to love. I once heard of the incapacitating effects on unloved children who are thrown upon their own resources and therefore need to defend themselves. Now I realize how suspicion is thus aroused when there are no expectations of kindness, and there is the necessity to prove one's worth and to conquer by frantically reaching for power and prestige in order to please everyone and to avoid criticism which arouses intense anxiety.

Ways to Accept Responsibility

"Our discussions showed me some of the ways in which I could accept my responsibility for establishing the kind of atmosphere in which students, co-workers, and patients would want to bring their problems to the surface and thus develop the ability to find themselves. *Angry Boy* showed a need for understanding, affection and patience to be one's natural self. Our problem students are portrayed in *The Quiet One* who couldn't learn because he hated everyone. *The Feeling of Rejection* was felt through the girl who was overprotected from natural play and forced to play by herself while her baby sister had all the attention.

"I see more clearly now why I am not more comfortable with students. Fearful of their hostility and anger, I could not see them as individuals. I was afraid to be too friendly. By doing most of the talking when with them they were not helped to express themselves. As a nursing instructor it will be necessary for me to lessen another's resentment over an issue. An act of deference on my part may divert anger. A friendly sort of humor is generally appreciated when it denotes relaxation and tolerance, especially when it is by a person in authority who can give it at his own expense.

"Thus it will be necessary for me to accept myself as a person who has gained self-respect, freedom from abnormal

(*Continued on page 45*)

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Commentary

by Louise Candland, R.N. and Erica J. Koehler, R.N.
Industrial Nursing Editors

MOST industrial nurses think they understand clearly what they expect of their management, but they do not always know what management expects of them. Consequently there may not be a smooth exchange of objectives, and the fulfillment of the objectives is carried on independently by the nurse and management, sometimes with overlapping or conflicting results. When the nurse and management work together in the promotion of related programs, the outcome is good.

The skills of the nurse working in industry are used most effectively where management has been enlightened to appreciate her capabilities. How, then, can a nurse bring about this happy situation? She must be able to explain herself, her qualifications, her objectives to management in terms it can understand. She must also try to understand management's objectives and point of view. There should be a free exchange of ideas so that both management and the nurse can work out a program that is mutually acceptable.

It would be easier for the nurse to understand the employer's point of view if she acquired a good knowledge of his functions and responsibilities. What are his desires and how can the nurse fit her program within the framework of these desires? If, for example, absenteeism is a costly item in his production, how can she explain that she could help reduce these costs? The explanation, to be effective, must be specific and show some time limit as to expected results. This is especially true when a program may require the outlay of additional costs in equipment and time.

If a program is accepted by management, the nurse then has the responsibility of testing the effectiveness of her efforts and of reporting progress from time to time. If the plan has been carefully thought out and has the support of management it should show positive results, although this is not always true. If good results do not follow, the program should be reviewed to find out where it has gone wrong. It may simply be a lack of understanding on the part of others—foremen, supervisors, etc.—whose cooperation is necessary, or it may be that although the objective was good, the method used was unworkable.

A nurse should not just assume that an executive is uninterested in her work or is too busy to offer the cooperation she needs and wants. A man is an executive because he has demonstrated his ability to plan and to delegate responsibility. If the nurse has not informed him that a real problem exists, one which can have serious effects on his production, he has a right to believe that everything is progressing smoothly.

For example, both management and the nurse may be aware that the problem of absenteeism is seriously curtailing efficient production. Management has not realized that the solution of part of this problem lies in the field of health maintenance which should be within the province of the nurse. On the other hand, the nurse may have had ideas on how absenteeism might be controlled by means of health conference and follow-up but has been reluctant to offer these ideas because she thinks she would be interfering with the authority of the personnel department or the foremen. Most of the time this is a failure in communication which is partly the responsibility of the nurse. If management or the foremen believe that her function is merely that of first aid and emergency treatment, it is up to her to alter this thinking.

An industrial health program can become static if a nurse fails to enlist the support of management in new ideas. Her timidity in offering new projects may hide a fear of criticism, a feeling of inadequacy, or reluctance to admit the need of assistance.

Where there is good rapport between the nurse and all others interested in conserving human resources as well as in increasing production, the medical department is an economic asset. This is the concept of management which the industrial nurse must first understand. From this fundamental premise stem her accomplishments, her personal satisfactions, and her acceptance by management as a valuable person within the organization.

Brain Tumor

(*Continued from page* 18)

scribed in some cases to prevent convulsions.

Food and fluids are given by mouth as soon as the patient's condition permits. Fluid intake, as before surgery, is usually limited to 1500 cc each 24 hours to prevent an increase in intracranial pressure. Fluids may be administered intravenously or subcutaneously if necessary with the same precautions as before surgery. Tube feedings are resorted to on the fourth or fifth postoperative day if the patient is still unable to eat and drink at this time.

Elimination by bowel and bladder should be attended to as required by the patient's condition in the same manner as before surgery. Protection from injury should also be provided for as indicated preoperatively.

Although utmost care is exercised in regard to aseptic technique during the operative procedure and when changing dressings, antibiotics are administered postoperatively for prophylaxis against infection.

Rehabilitation

As his condition improves, the patient should be helped to resume normal activities according to his ability. This program of rehabilitation begins with such simple tasks as feeding himself, and may eventuate in resumption of all the activities in which he engaged prior to the onset of the illness. Many patients who undergo brain surgery are less fortunate than this, and are left with various types of disability such as paralysis, speech disturbance, blindness, or defects of intelligence. In such cases, the patient should be helped to accept his limitations, to adjust to them, and to utilize his remaining abilities to capacity. His family also should be helped to adjust to the situation. If the task of rehabilitation seems to be beyond the ability of the nursing staff, the Social Service Department of the hospital may be able to supply psychological support, as well as information regarding convalescent care, possible future employment, sources of financial aid, etc.

Summary

Skill, intelligence, and sympathetic understanding are essential in the care of the patient with a brain tumor.

During the period before surgery, attention is focused on the establishment of a definite diagnosis. The nurse assists in this matter by careful observation and recording to symptoms, as well as by preparing the patient for diagnostic procedures such as neurological examination, spinal tap, pneumoencephalogram, and ventriculogram.

It is also the responsibility of the nurse at this time to attend to the patient's nutritional needs, fluid intake, and elimination; to protect him from injury from falls, bumps, etc.; to administer drugs for relief of pain as prescribed by the doctor; and to provide psychological and spiritual care as indicated.

While the patient is in the operating room, his family should be treated with consideration and should be given occasional bits of information about the progress of the operation if possible.

On his return from surgery, the patient is placed on his unaffected side until he reacts from the anesthetic. The head rest is then elevated and the patient is moved from side to back to side every two hours. He is not allowed to lie on the affected side.

Central hyperthermia and increased intracranial pressure are the two most dangerous postoperative complications. The former is controlled by tepid sponge baths, ice bags, and ice packs; the latter, by elevation of the head of the bed, limitation of fluid intake, spinal or ventricular tap, intravenous administration of hypertonic solutions, and ad-

(*Continued on page* 45)

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Let's Talk It Over

(*Continued from page* 41)

fear, and guilt but still in need of understanding and security while accepting these same basic needs in students, patients and co-workers. Is there reality in the assurance that group work becomes easier with practice? Can I exercise the necessary leadership to bring about constructive results and the democratic freedom necessary for the establishment of ideals, self-respect and self-confidence? Criticism and resentment of others then do not break down and pervade the atmosphere which needs to be permissive for real learning which helps others to develop into secure, responsible individuals.

"Obviously, the whole issue of our human destiny comes back in the end to our individual selves. Profoundly as we are influenced by the institutions and customs of our culture-forces that took shape long before we were born, there is in all of us a margin for initiative. In some small way, or in some greater way, we can act maturely instead of immaturely. The sum of our mature acts, to each and all of us may make the difference between a world headed for destruction and a world headed for creative fulfillment."

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Brain Tumor

(*Continued from page* 43)

ministration of saline cathartics.

During the postoperative period, provision must be made to insure adequate nutrition and fluid intake, proper elimination, relief of pain, control of restlessness, prevention of infection, and protection from injury. As the patient progresses, he and his family should be given whatever help they may need to facilitate adjustment and rehabilitation.

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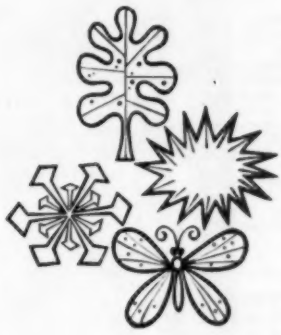

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